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ABSTRACT

These proceedings contain an introduction and 26 papers arranged in five sections: (1) People's Republic of China and Taiwan (Republic of China); (2) Hong Kong, Singapore, and Thailand; (3) Korea; (4) Japan and the Western Pacific; and (5) United States. Paper titles and authors are as follows: "Recent Social Security Policies and Developments in the People's Republic of China (PRC)" (Liu); "Long-Term Care for the Elderly in China" (Liang, Gu); "Retirement Policy, Health and Social Services for the Elderly in Shanghai" (Wong); "Informal Social Support Systems in China" (Liu); "Cognitive Impairment among the Elderly in Shanghai, China" (Yu et al.); "Intergenerational Relations in Contemporary China--Descriptive Findings from Shanghai" (Barusch et al.); "Family Structure and Elderly Problems in Taiwan" (Shu); "Taipei Municipal Government Budgetary Issues for Elderly Services" (Bai); "The Family as a Social Welfare Support System for the Elderly in Taipei, Taiwan, Republic of China" (Yang); "Need of the Elderly for Home Care Services in a Changing Society--The Case of Taipei Metropolitan City" (Chan); "Survey of an Interdisciplinary Study on Aging in Taipei--Sample, Instrument and Interview" (Hsieh); "Welfare Policies for the Aged on Both Sides of the Taiwan Strait--A Comparison" (Tsai); "The Coping Behavior of Caregivers in Hong Kong" (Kwan); "Segregated Housing and Residential Services for the Chinese Elderly in Hong Kong" (Ngan); "Social Support Networks for the Elderly in a High Rise Public Housing Estate in Singapore" (Cheung); "The Impact of Living Arrangements of the Elderly on Government Programs in Thailand" (Wongsith); "Operation and Development of Programs for Community Care for the Low Income Elderly in Seoul" (Cho); "Indicators of Health Status of Older People in Korea" (Koh); "The Korean-American Urban Elderly" (Kim, Kim); "The Roles of Government, Family, and the Elderly Individual Caring for Older Persons in Japan" (Maeda); "An Overview of Aging in the Western Pacific" (Andrews); "Gerontology in Higher Education in the United States" (Rich); "A Theoretical Overview of Ageism in the United States: Criticisms and Proposals toward a New Outlook" (Jan, Thacker); "Direct Care Personnel Shortages in Long-Term Care: Global Implications" (Cowart); "Quality of Care in Sheltered Housing--Regulation or Education?" (Streib); and "Financial Models for Long-Term Care: USA" (Sutton-Bell). (NLA)

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PRESENTATIONS

**ASIA-U.S. CONFERENCE
ON
SOCIAL SERVICES
AND AGING POLICIES**

Pensacola, Florida
August, 1991

**Editor:
Harold L. Sheppard, Ph.D.**

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SOCIAL SERVICES AND AGING POLICIES IN THE U.S. AND ASIA

August 8-11, 1988

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INTRODUCTION

Harold L. Sheppard

This volume is the product or outcome of the second Asia-U.S. Conference on Social Services and Aging Policies, held in August, 1988, at Pensacola, Florida. The primary organizers and sponsors of this international meeting were the Florida-China Linkage Institute at the University of West Florida, and the International Exchange Center on Gerontology (IECG). The Center is a multi-university organization, based at the University of South Florida, in Tampa -- an organization whose primary missions include the exchange and dissemination of information regarding policies and practices concerning the elderly in countries around the world.

The first conference took place in mid-1986, in Taipei, Taiwan, and focused only on Taiwan, Hong Kong, and the United States.[*] The Taipei meeting was, in my opinion, a landmark event, because it launched what the planners and sponsors hoped would be only the first step in an ongoing program of exchange of aging policy and practice information, and of cross-national research. This new publication is one indicator of the success of that objective: contacts were made among the participants in the Taipei conference, which have resulted in continuing relationships, joint presentations, visiting lectureships, etc.

Just as important as these results, the first meeting stimulated an expansion of contacts and interest on the part of gerontologists and other aging-related program officials from other societies around the "Pacific Basin" -- most notably, Japan and the People's Republic of China, as well as Thailand, Singapore, and South Korea. The Table of Contents for this publication provides the reader with evidence of the growth of interest in such efforts that originated through the initiative of the IECG, the University of West Florida, with the enthusiastic and material support of Hsiu-Hsiung Bai, Commissioner of Taipei's Bureau of Social Affairs. The list of the other individuals and organizations making that first meeting possible is much too long to mention here. Dr. Glen Goltermann, of the University of West Florida, and I wish to acknowledge our gratitude for and appreciation of, their indispensable contributions and support.

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[*] Social Service and Aging Policies: Taiwan, Hong Kong, and the United States, published by the International Exchange Center on Gerontology, 1988.

We must call special attention to the efforts of Professor William T. Liu, who made possible the participation of several researchers associated with the pioneering project based at the Institute of Mental Health of Shanghai. That project, described and reported on in several of the following chapters, is among the very first large-scale longitudinal research programs using interview instruments tried and tested for cross-cultural analysis purposes among American and Chinese social and medical scientists interested in problems of the elderly. Professor Liu is an internationally recognized sociologist whose perspective and conceptual approaches to mental health and aging are embedded in the cultures of both the United States and China (including Taiwan). His association with the activities culminating in the several papers presented at the 1988 conference, and his unstinting cooperation with IECG and the other Florida-based indviduals and organizations, constitute an honor bestowed upon the organizers of that meeting.

As editor of this publication, I take responsibility for arranging the chapters in the fashion displayed in the Table of Contents -- primarily by major regions represented at the Pensacola conference. Those papers dealing with the elderly in Taiwan (the Republic of China) and on the Chinese mainland (the People's Republic of China) are assembled in the first part of the book, partly because they provide an opportunity for the reader to indulge in some comparisons, and partly because the last chapter in that section (by Wen-hui Tsai, of Indiana/Purdue University) does indeed represent one example of a comparison of "elderly systems" in both societies.

The first twelve chapters, however, deal separately with the PRC and the ROC (Taiwan). We are all aware by now of the billion-plus population of the People's Republic, but the general publics of the United States and of many other countries may not be acquainted with the aging-related issues emerging in the PRC -- nor for that matter, in Taiwan, which has a relatively more "developed" economy and society than does the PRC. We are fortunate in having as the first chapter a report on recent social security policies and trends in PRC by Dr. Lillian Liu, of the U. S. Social Security Administration. We have placed Dr. Liu's chapter first largely because it was the only contribution at the Pensacola conference that dealt with this crucial issue -- the issue of retirement income in a changing society/economy such as the PRC. Her contribution is one of the most thorough English-language descriptions and histories of developments of this topic covering the People's Republic.

For many gerontologists, the emerging problem of long-term care for the elderly is not unique to the so-called "developed" urban-industrial societies that have already moved into a stage of "modernization." Dr. Jersey Liang -- with Shengzu Gu -- paints a picture of a complex mosaic of programs and policies in the PRC, after first reporting on population aging in that country and the health conditions of its elderly. The key focus of their chapter is on the nature of the long-term care system -- involving a centralized policy-setting within a tradition of family support, "ruralism," and even some signs of private-sector ingredients.

The next four chapters of the volume refer more specifically to programs, policies, and empirical studies about Shanghai, and not more generally to the PRC as a whole, although the authors do present some country-wide policies concerning retirement, health and social services. Dr. Chang-Hua Wang, a physician at the Shanghai Institute of Mental Health, writes precisely on such policies (Chapter 3), and then directs our attention to Shanghai itself. One of the chapter's unique features is that it provides information about gerontological and geriatric organizations within the city, and their roles in the lives of Shanghai's elderly.

Chapter 4 is authored by Professor William Liu, who concentrates on the informal social support system in China, with special attention to the centrality of the family. As Professor Liu stresses, "it is impossible not to touch upon the role of the family, which in a sense differs from our normal usage of the word in the West." How official state dogma regarding collective identification, on the one hand, and the persistence of traditional family solidarity, on the other, relate to each other (if at all) is one of the chapter's stimulating sections.

On a more empirical level, Chapter 5 (co-authored by a team of American and Shanghai researchers) represents a substantial part of the first findings from the Shanghai longitudinal survey based on interviews with more than 5,000 men and women 55 and older in that immense urban area. The more specific topic of the chapter has to do with cognitive impairment in the elderly population. It is impossible to summarize adequately the research results and interpretations presented in this 32-page chapter. The reader will be interested in learning to extent the which the findings (with emphasis on their tentative nature) from the Shanghai survey prevalence rates of cognitive impairment compare with those already reported for American urban areas, and in pondering the issue of balancing sociological survey results with the "clinical/epidemiologic perspective."

Chapter 6 represents a "success story," in that it stems in large part from the prior participation by the American author (Professor Amanda Smith Barusch, of the University of Utah's Graduate School of Social Work) in the first conference referred to earlier. Together with four Shanghai co-authors, she reports here on a study inquiring into three major components of the PRC's support system for the elderly (pensions, employment, and family care) with special attention to intergenerational relationships. They looked into the "norm of reciprocity as it is evidenced in the Chinese cultural context." Their interpretation of the findings deserve serious consideration by students of cross-cultural gerontology.

Chapters 7 through 12 focus on Taiwan (ROC). Once again, I want to recognize the importance of the many scholars, administrators, and official organizations in Taiwan who are concerned about aging-

related developments in that society -- a society which is rapidly undergoing "population aging," along with progress in economic growth. Their importance lies in enhancing the multi-purpose exchange programs which form part of the rationale for the International Exchange Center on Gerontology. Taiwan's outstanding academic institutions are increasingly devoting attention to the gerontological dimensions of population aging, and three of the chapters are authored by representatives of those institutions
-- Ramsay Leung-hay Shu (Academia Sinica); Shou-jung Yang (Soo Chow University); Hou-sheng Chan (National Taiwan University); and Kao-Chiao Hsieh (also of National Taiwan
University).

Professor Shu's chapter on family structure and problems of the elderly constitutes a factually based exposition of the impact of "modernization" (or industrialization, etc.) on subtle but fundamental changes away from the "extended kinship system [which] was idealized for thousands of years" and toward the dominance of the nuclear family -- and what this social and economic phenomenon entails for the status and welfare of the elderly, especially as the modernization process may continue. Shu's policy recommendations at the end of the chapter should not be considered as applicable only to Taiwan. The chapters by the other academic researchers should be weighed partly within the context of Professor Shu's conceptual and policy-related contribution. Commissioner Bai, of Taipei's Bureau of Social Affairs (as previously noted, a prominent supporter of the first conference) Commissioner Bai has written on the critical topic of government budgetary issues that must be faced in the preparation and provision of services to the elderly. "The prolongation of the life expectancy for Taipei citizens," he writes, "is evidence of an aging society. What should be done to cope with problems resulting from this major transition in society? How do we satisfy the social needs of such large numbers of the aged?" In Taipei alone, from 1968 to 1987, the 65+ population as a proportion of that city's total population more than doubled. Bai's presentation and discussion of the policy and program responses to these and other questions make for a detailed and instructive chapter.

The chapter by Hsieh is included here primarily because it might provide the basis for encouraging other gerontological survey researchers from other countries to carry out cross-cultural studies bearing on the same topics and, at the same time, alert them to the problems entailed in organizing and managing an inter-disciplinary research project. As the author points out, such problems are discussed in depth in order to emphasize the serious nature of such projects.

As already indicated, one of the primary reasons for the Asia/ U.S. conferences started in 1986 was to encourage comparative policy research studies; Wen-Hui Tsai's chapter on welfare policies on "both sides of the Taiwan Strait" is an example of such an effort. Tsai's chapter on this topic is based on his stimulating paper presented and discussed at the 1988 conference. I hope that it will prompt more such serious contributions to the field of cross-national gerontology-related policy analyses.

The chapters in Part I, devoted to "both sides of the Taiwan Strait," make up more than half of this volume's pages. But the reader will no doubt accept the reasons for this disproportionate share, given the size of the aged population. The four chapters in Section II concentrate on Hong Kong, Singapore, and Thailand -- the latter two countries represented for the first time in our program of conferences on social services and aging policies in the United States and Asia. The third conference is scheduled for December, 1991, in Hong Kong.

Professor Alex Kwan, of Hong Kong's City Polytechnic (Department of Applied Social Studies), is well acquainted with the professional literature in the United States and elsewhere, about what is also emerging in Hong Kong, namely, the problems of *caregivers* of the elderly. Starting with clarification of the facts concerning the continuing importance of the elderly's adult children in providing help and care to them in the U.S., for example, Kwan writes (in Chapter 13) that "gerontologists in *developing* countries are now challenging the notion that all families are able to provide good care to older relatives in the face of rapid social and demographic changes. *These changes are occurring in developing nations at a much faster pace than they did historically in the developed world."* Kwan's chapter is a preliminary report on this issue as it applies to Hong Kong, with special attention to the methodology and types of measures used.

Raymond Ngan (also of Hong Kong's City Polytechnic) takes up the never-ending controversy over the worth of age-segregated vs. age-integrated housing and residential services for the elderly, as it applies to Hong Kong. "Contrary to the...official policy of 'care in the community,' nearly all the different types of residential care services for the elderly...have been developed in age-segregated forms." Ngan reports that there are few attempts to promote intergeneration contacts even when there might be a few housing projects ("estates") of a non-segregated nature -- "in the community" but segregated from the rest of the population." More to the purpose of Ngan's chapter, he deals with the critical question of whether such residential and services programs meet the needs of, and promote, the mental health of

Hong Kong's elderly -- and if not, what changes are needed to improve the situation? His chapter (which, incidentally, also provides some material on Singapore) is valuable not only because of its empirical findings, but also because of the author's comprehensive understanding of the perspectives on the issues highlighted in much of the professional and scientific literature in many countries.

The situation in Singapore, as reported in Chapter 15 by Paul P.L. Cheung and his colleagues, of Singapore's National University, is a case study in the consequences of immigration, demography, and aging. The elderly in Singapore have been increasing in numbers *and* as a proportion of the total population, at a rapid rate. This phenomenon "injects a new sense of urgency in dealing with the growing welfare burden of the aged....With the rapid socio-economic changes and growing Western influence on the Singapore way of life, there is a growing concern of whether the traditional support systems for the aged will continue to function effectively." According to the authors, until the inauguration of the project described in his chapter, there had been no systematic research in Singapore designed to assess the balance of formal and informal support for the elderly, a problem made more complex given the multi-racial nature of Singapore's population. They report on such research, sponsored by Japan's United Nations University.

Professor Wongsith's report and discussion in Chapter 16 are an outgrowth of a broader multi-country project on the socio-economic implications of population aging funded by the government of Australia. Dr. Wongsith is affiliated with Chulalongkorn University's Institute of Population Studies, Thailand. She describes the results of that survey in Thailand, the purpose of which was to present that country's policymakers and planners with data on the demography, attitudes, perceived needs, and other facets of the 60-plus population. In addition to such empirical information, the chapter gives us a portrait of the Thai elderly's power and status (especially in the rural areas), the significance of joint households, etc. The extent to which (1) the elderly are aware of programs for the aged, and (2) if they make the final decisions on important family matters -- as well as the qualitative facets of intergenerational relations -- are among only a few of the special features of her valuable 50-page contribution to this volume.

Part III consists of material on the elderly in Seoul, South Korea, and on elderly Korean-Americans. Ki-dong Cho, of HelpAge of Korea, outlines in Chapter 17 the operation of community care for Seoul's low-income aged. Cho is concerned about the possibility that they (the Koreans) "unfortunately...do not yet have a system to replace the Confucian ideas. In rural areas the young people move away and the elderly are left alone, and in the cities the high rise flats can often not accommodate elderly parents or relatives." The latter observation applies to growing urban societies beyond that of Korea.

HelpAge believes that the problems and stress of the poor and lonely elderly are growing, and thus the establishment of a program of home help staffed by volunteers from the community was made necessary. Cho reports on a survey conducted to determine the needs and attitudes of this particular segment of the urban aged population, as one basis for designing the Home Help program. It is rewarding to cite Dr. Cho's satisfaction in finding that volunteer-recruitment was easier than anticipated.

Chapter 17 is followed by an Addendum, by Prof. James Y. Koh (of Florida A & M University in Tallahassee), on indicators of the health status of Korea's older persons, with additional information on the demographic trends in the Republic of Korea.

From Korea itself we turn in Chapter 18 to Koreans in urban America, as reported by Jung-Sup Kim and Paul H.K. Kim (of the Korean-American Christian Service Center and Louisiana State University, respectively). The Kims forcefully argue, in the course of presenting the results of empirical reports and their own knowledge of the situation, that the problems of Korean elderly in the United States require a corps of bilingual professionally trained social workers, "free from politics of organizations and encouraged to be creative and accountable." When one considers that there now are about 800,000

Korean-Americans and that at least 10 percent of them are elderly, their comment should not be taken lightly.

The International Exchange Center on Gerontology was honored in having Professor Daisaku Maeda, a leading gerontologist in Japan, accept the Center's invitation to present a paper on the situation of the elderly in that country, published here as Chapter 19. At the time of the Pensacola conference in 1988, Prof. Maeda was Director of the internationally esteemed Tokyo Metropolitan Institute of Gerontology's Sociology Department. Since "retiring" from that long-held position, he is now affiliated with the Japan College of Social Work. The story of "population aging" in Japan is one of a society undergoing an unrivalled rate of growth in numbers and proportion of the elderly, within only a few brief decades. Maeda's chapter (in Part IV) focuses on the roles of government, family and the elderly themselves in caring for the aged in this dynamic society.

According to Maeda, Japan -- compared to other industrialized countries -- preserves to a greater extent the pattern of family care of the elderly. He attributes this difference primarily to the delayed industrialization of the country. Other social gerontologists cite this greater role of the family as an indication of the persistence of *traditional culture* of the country, despite the theory of "modernization." The fact that less than 2 percent of the elderly are in institutions is cited as an example of the contrast; Maeda elaborates on the differences between Japan and Euro-America in cases involving seriously impaired older persons, as far as the roles of spouse and adult children are concerned. Furthermore, in Japan the proportion of the aged living with their adult children far exceeds that of other similarly urbanized, industrialized societies, although it is pointed out that the Japanese proportion has been declining.

Nevertheless, the role of government in caring for the elderly "is becoming increasingly larger." Maeda then goes on to discuss this development in terms of the administration of legislation dealing with the legal responsibility of children toward their aging parents. A major contribution of this chapter consists of national survey data on adult children's *plans and expectations* regarding care of their parents if and when they become bedridden -- *and* the actual facts. The reasons for the reported decline in the proportion of adult children providing economic support are discussed in detail by Maeda.

Part IV also contains a chapter ("An Overview of Aging in the Western Pacific") by an internationally active personality in the field of gerontology and geriatrics, Dr. Gary Andrews, from the Centre for Aging Studies, at South Austrialia's Flinders University. Andrews directed a World Health Organization collaborative study on population aging and related problems in four Western Pacific countries -- the Republic of Korea, Malaysia, the Philippines, and Fiji. The importance of this project lay in its function of "awareness raising," by and about the developing societies of the world. This function is over and above the more obvious one of providing heretofore unavailable information about the older population in these particular four countries. Andrews also succeeds in giving us some of the personal dimensions in the experience of designing, administering, and analyzing the separate surveys' results -- the problems of cross-cultural research, in other words. The challenge of developing standardized instruments for cognitive testing is but one example. Andrews' treatment of the many comparative findings of this pioneer endeavor makes delightful reading.

It should be noted that this particular project formed one of the bases and rationales for a much larger special program for global research on aging now being promoted jointly by the World Health Organization and the U.S. National Institute on Aging. It will focus on four priority areas cited in Andrews' chapter.

Five chapters make up the final section of this volume, Part V, which deals with (a) selected aspects of the American gerontology scene, and (b) global outlooks by American gerontologists. Thomas Rich writes in Chapter 21 of the development of gerontology as a formal field of education in American universities, a topic on which he is eminently qualified, having been a founder of one of the first two degree-granting programs in the United States -- at the University of

South Florida. His historical treatment of the subject should be valuable for readers of this book, both within the United States and abroad. "Gerontological education", he writes, "has come a long way since the early 1950s. It has reached a point of acceptance and indeed enthusiasm..." Other countries are only beginning to consider or initiate such university programs; they should benefit from his essay.

In Chapter 22, Lee-jan Jan and Anne Thacker (of West George College) present their theoretical perspective on what continues to be a topic in gerontology, namely, ageism in the United States -- not that the U.S. has a monopoly on that negative attitudinal and behavioral syndrome. The authors' treatment of the subject is useful in that it deals with, among other things, the controversy surrounding Cowgill's *modernization theory*, the *minority group* hypothesis; *disengagement theory* etc. Jan and Thacker conclude their chapter with some suggestions for further research on these and related topics. Their addendum (pages 488 and 489) stems from their critical observations and views about the other papers presented at the Pensacola conference.

Dr. Marie Cowart (of Florida State University) deals in Chapter 23 with an issue about which she is a reputable scholar -- the issue of personnel requirements in the burgeoning field of long term care for the elderly. That problem applies to more than to such countries as the United States and Great Britain. The issue, as she asserts, "has relevance for other...newly industrialized nations." This viewpoint is not a matter of self-aggrandizement on the part of the "health industry" professions. It has serious implications as far as the well-being of the elderly themselves is concerned. Cowart raises in this chapter some burning questions still to be resolved, e.g., the use of temporary personnel; the "insidious substitution of technology for personnel" (instead of assessment decisonmaking by professional personnel); and public policy incentives designed to increase caregiving by untrained family relatives -- despite the fact that families are already providing virtually 80 percent of such care. The challenge of making elder care an attractive career for qualified men and women still persists, and will grow in developing as well as in "developed" societies. Is this attributable at least in part to a low esteem for our elderly populations?

In Chapter 24, one of the leading gerontologists active over the past several decades, Dr. Gordon Streib (University of Florida), takes up the issue of regulation/legislation vs. education as ways of assuring the elderly a high quality of care in sheltered housing, defined here as "more than a housing unit." Streib walks us through the questions of why the government should be involved, in the first place; the regulation vs. education issue; and then uses Florida as a case study to illustrate how quality of care is affected by the regulatory and educational processes. What is more important, from the standpoint of a primary purpose of the International Exchange Center, is Streib's emphasis on how one country might fruitfully borrow a practice or idea from other countries, and adapt it to local needs of the aged. Sheltered housing -- adapted from Great Britain -- and *ombudsmen*, from Sweden -- are examples cited by Streib. He epitomizes, in my view, the social scientist gerontologist/advisor who has a global, comparative gerontology outlook which is in short supply in the field.

In the final chapter of the Pensacola conference proceedings, Dr. Nancy Sutton-Bell, of Florida State University's College of Business, focuses her discussion of alternative models for funding long-term care for the elderly in the United States within private-sector boundaries, recognizing that lengthy nursing home stays can lead to the exhaustion of personal financial resources by the elderly. She stresses the principles of risk pooling, sharing, and transfer, even though she states that cash accumulation plans -- which "may prove to be inadequate in financing long-term care directly" -- should be encouraged. Her chapter also deals with insurance and service plans. The problems of the American elderly derive partly from the limited provisions of the major "social insurance" health program, Medicare, which focus on *acute* illnesses, not *chronic* ones. This limitation is one basis of the long-term care plight of the elderly. This applies especially to the aged in the United States, one of few industrialized countries in the world without a comprehensive public health care policy designed to meet the long-term care financing problem beyond the private approach.

As long as the United States pursues its present orientation about such issues, the challenge, as Dr. Sutton-Bell puts it, is for the American insurance industry to "provide actuarially sound products at affordable prices covering a risk that has both a high probability of occurring and a high potential severity in terms cost." That private-sector industry so far lacks the type and quality of data for evaluating the parameters and components of this "new phenomenon." Whether the United States, in the spirit discussed by Gordon Streib in the previous chapter, also considers how other societies are coping with the challenge so far remains unresolved. The issue has become one of more than academic concern, and currently (as of the end of 1991) is on the center stage of the political theater in the United States.

* * * *

The more than two dozen chapters in this publication were based on materials presented at the Second Conference on Social Services and Aging Policies in the United States and Asia, in 1988. We hope the timing of its availability is appropriate, given the fact (as already noted) that the third such conference is scheduled for December, 1991, in Hong Kong. The objectives of such assemblies are to stimulate collaborative research, and especially to exchange information about the topic among academics, practitioners, and administrators from a wide variety of societies in the "Pacific Basin." The progress toward meeting such objectives is naturally slow and cumulative. But I am encouraged by the degree and nature of that process, including the opportunities of the participants -- from East and West -- to be invited as lecturers -- from West to East.

Since we are now witnessing and experiencing a rapid "global aging," these types of encounters, I believe, will redound to the benefit of all.

CHAPTER 1

RECENT SOCIAL SECURITY POLICIES AND DEVELOPMENTS IN THE PEOPLE'S REPUBLIC OF CHINA

Lillian Liu

Introduction

The leaders of the People's Republic of China (PRC) began introducing a series of modernization initiatives to improve the country's economic well-being in 1978. In recent years, however, they have become aware that economic reforms did not always bring improved conditions to all segments of the population. Developments for elderly welfare have evolved primarily as ad hoc responses to challenges posed by the post-1978 reforms. This chapter reviews the impact of economic reforms on the aged and assesses recent policies and developments at both central and local levels in the area of old-age income security.

It has been a decade since the Chinese leaders embarked on a course of reform and modernization in 1978. In China, as elsewhere, one of the ultimate purposes of reform and modernization is to improve the living standards and welfare of the people, the aged included. More specifically, PRC leaders aimed to lessen the burden of over-population, to promote economic efficiency, and to instill economic responsibility and accountability; that is, to wean the population, urban and rural, from heavy dependence on collective and state protection for their income security. We have been witnessing a restructuring of the country's economic system as China attempts to gradually move from one that has been dominated by a command/planned economy to one with more market-oriented characteristics.[1]

PRC leaders, however, were slow to realize the social consequences of their economic reforms. Social security reform in the last decade developed primarily in an ad hoc manner, in response to challenges posed by the post-1978 economic reforms, rather than according to a coherent national plan. The results of this reactive approach to social security have led to an unexpected impact on the aged population.

In rural China, where agricultural reform has been economically successful, the pre-reform infrastructure for income security of the disadvantaged population, the elderly included, disappeared within a short period. In the cities, on the other hand, where economic reforms have had only limited success, economic reforms and the existing social security system have often been at cross- purposes.

The Seventh Five-Year Plan. To address these problems, the PRC State Council included a special section on social security in its Seventh Five-Year Plan, issued in 1985. The document establishes several guidelines for developing a coordinated social security system by the year 1990. For example, it proposes, among others, that (1) the system be affordable and compatible with existing conditions, (2) the system consist of "multi-layered" programs providing social security for different segments of the population, (3) the government should not be the only source of funding for social security benefits, and (4) the strong support by traditional networks of family members, friends, neighbors and local communities be upheld.[2]

In order to provide the context of these proposals, and assess their significance, a brief description of social security from 1949 through 1978 will be presented next. The changes and problems that resulted from some of the post-1978 reforms will then be discussed. Finally, some of the measures undertaken to remedy the problems will be reviewed, and possible directions for fulfilling the Seventh Five-Year Plan explored. Before addressing these issues, however, a clarification of the term "social security" is in order. "Social Security," as defined by the Chinese, has a much broader meaning than in the United States. It entails the totality of government and non-government sources of support that provide cash and in-kind benefits to the population. This report refers to sources of retirement income only.[3]

Old-Age Support: 1949-1978

From 1949, the year the People's Republic was created, until the inauguration of the post-1978 reforms, there were two sources of support for the Chinese elderly: the family and collective or state programs. Family was an important source of support for both rural and urban inhabitants, partly because of Chinese tradition, and partly because the government upheld this tradition by incorporating it in the Marriage Law as early as 1950. The adult children's filial duty to care for aging parents also became a legal responsibility.

Collective and state programs were introduced by the government shortly after 1949. One of the hallmarks that distinguished the PRC policies from those of the pre-1949 Nationalist government was the creation of the all-encompassing collective and state infrastructure that has since both dominated the country's economic activity and provided income security for the population. The degree of old-age support provided by collective and state institutions, however, varied widely for workers in rural and urban sectors.

The Rural Sector: Communes

Rural workers made up about 75 percent of the total civilian labor force. They depended on agricultural collectives (i.e., communes since 1958) as the major source of support in old age -- primarily in the form of in-kind benefits. Communes were simultaneously economic and political/administrative entities, to which all rural workers belonged. Individual production teams in communes provided grain rations for all of the workers and their dependents. In addition, communes routinely allocated up to three percent of the total production into a welfare fund to support cooperative medicine for their members. The same welfare fund also financed the "Five Guarantees" program to provide subsistence living to the indigent who, for various reasons such as age and health conditions, could not take part in agricultural production, and who had no families to care for them. The "Five Guarantees" included food, clothing, shelter, medical care and burial expenses. Over 80 percent of the recipients of these benefits were indigent elderly who had no surviving family members. Other "Five Guarantees" recipients were disabled and orphans, for example.[4]

The Urban Sector: State Sector Social Insurance

For urban workers, a great majority (64 percent in 1952; 78 percent in 1978) were employed by the state sector. These were employees of state-run enterprises and party and government organizations, including educational, scientific and cultural institutions. By 1978, these state-sector employees made up almost 19 percent of the total civilian labor force. The remainder of urban workers, or 5 percent of the civilian labor force, were employed by urban collectives, such as co-operatives, stores, factories and various service-oriented establishments.[5]

Table 1
Labor Force and Employment in the People's Republic of China, 1952-1987 (millions)

	1952	1978	1984	1985	1986	1987
Total Population	574.82	962.59	1,038.76	1,050.44	1,065.29	1,080.73
Rural	503.19	790.14	707.40	665.98	624.26	577.11
(% of Total)	(87.5%)	(82.1%)	(68.1%)	(63.4%)	(58.6%)	(53.4%)
Urban	71.63	172.45	331.36	384.46	441.03	503.62
(% of Total)	(12.5%)	(17.9%)	(31.9%)	(36.6%)	(41.4%)	(46.6%)
Civilian Labor Force	207.29	401.52	481.97	498.73	512.82	527.83
(% of Total Population)	(36.1%)	(41.7%)	(46.4%)	(47.5%)	(48.1%)	(48.8%)
Employment by Sector						
Rural/b	182.43	306.38	359.68	370.65	379.90	390.00
Urban	24.86	95.14	122.29	128.08	132.92	137.83
State Sector/c	15.80	74.51	86.37	89.90	93.33	96.54
--Gov't, Party, and other inst.	5.40	14.96	21.25	23.22	24.61	25.89
--State Enterprises/d	10.40	59.55	65.12	66.67	68.72	70.65
Collective Sector	.23	20.48	32.16	33.24	34.21	34.88
Private Sector	8.83	.15	3.39	4.50	4.83	5.69
Others/e	--	--	.37	.44	.55	.72

Sources: Chinese Statistical Yearbook, 1988 (Zhongguo Tongji Nianjian, 1988.) Beijing, 1988, pp. 97, 153, and 155.
Monthly Bulletin of Statistics -- China, 1988:no. 10 (Zhongguo Tongji Yuebao). Beijing, 1988, p. 5.Notes:

a. In 1984 the Chinese redefined "urban areas" to include the newly formed townships and the like. Residents in these townships are now part of the urban population, thus contributing to the rapid increase in urban population.

b. Rural communes were established in 1958 and abolished in 1982-1985.

c. Includes government, party institutions and cultural, educational, scientific, and other institutions.

d. Includes contract workers (1987: 7.26 million).

e. These include joint state/collective, state/private, joint foreign PRC enterprises, etc.

The state sector's social insurance programs were governed by a series of regulations and instructions issued since 1951. Together, they provided state-sector employees with extensive cash and in-kind benefits. These included cash benefits for the elderly, survivors, and the disabled, or the rough equivalent of Social Security in the United States. In addition, they also provided cash benefits for sickness and maternity, free medical care, and in-kind subsidies such as housing, food, fuel, and other daily necessities and services.[6] In addition, some of the "large urban collectives," established by local governments at the county level or above, were granted the authority to provide their employees with programs similar to those offered by the state sector. These urban collective workers were entitled to programs comparable to those enjoyed by state-sector employees. The total number of the insured in this broadly defined state-sector social insurance plan is estimated as the total number of state-sector employees plus up to three-fifths of urban collective workers at different times.[7] In short, over 90 percent of the urban labor force, or roughly 23 percent of the total civilian labor force, were covered by the state-sector social insurance. The remaining urban workers had to depend on their families for old-age support. Neighborhood and resident committees presumably provided subsistence to the needy elderly with no families.

Under the state-sector labor insurance system, men could retire at age 60 after 20 years of general service, and receive a monthly benefit that ranged from 50 percent to 70 percent of pre-retirement wages, depending on the length of consecutive service. Female white-collar workers could retire at age 55 and blue-collar workers could retire at age 50. Retirees who had made a special contribution to society could earn an additional 15 percent of wages in their monthly retirement pay. There was no cost-of-living adjustment for these benefits for the reason that inflation was not supposed to occur in a Socialist economy. Finally, the employees themselves did not contribute to the financing of the programs. The work units (i.e., employers) were to allocate 3 percent of the payroll for labor insurance funds, with the tacit understanding that the People's Bank would subsidize whenever necessary.[8]

Very few older workers retired in pre-reform days, however. The Ministry of Labor estimated that, in 1978, some 2.6 million older workers were eligible to retire but had not done so.[9] There were several reasons. First, "radical" Maoists in the early 1970s considered "pensions" as "capitalist" material incentives. Healthy older workers seeking retirement were often considered as "anti-socialist" and, therefore, undesirable elements of the society. Secondly, many workers probably did not have much confidence in their work units' ability to administer the programs. During the Cultural Revolution (1966-1976), the Trade Union organizations responsible for managing the social insurance funds and administering these programs were disbanded. Consequently, individual work units became responsible for financing and administering these programs. Thirdly, in many cases, personnel records necessary to determine the workers' service tenure and benefit levels were in disarray, another side effect of the disruptions caused by the Cultural Revolution.[10] Finally, those who continued to stay on the job could receive full pay and did not necessarily have to perform.

Old-Age Support: 1979-Present

The Rural Sector: Communes Abolished

The effect of post-1978 modernization initiatives on old-age support varied between rural and urban sectors. For the rural population, extensive changes occurred rather swiftly. The abolition of communes over a period of two or three years removed collective protection for the elderly and placed the family as the all-important source of support.

Rural Reform and Its Impact on Social Programs. The rural economic reform that brought about the disappearance of communes in the early 1980s throughout most of China was, by all accounts, a resounding economic success story. In the process, family farming replaced collective farming. The reform enhanced individual families economic responsibility and, to a large extent, their economic independence from rural authorities. Farm production soared, while rural income and consumption rose.

On the other hand, collective programs (such as cooperative medicine) that had formerly provided over 90 percent of China's care, disappeared in a couple of years. Barefoot doctors either set up clinics for private practice or opted for more lucrative pursuits such as farming or rural enterprises. The Five Guarantees program, of which over 80 percent of the recipients are childless rural elderly, also suffered severe setbacks. The former production team or brigade leaders in the communes who routinely canvassed their village for needy residents also abandoned their charges to get rich. The administrative and funding mechanisms for these programs were supposedly transferred to the newly established village and township governments that replaced communes. But the the actual transfer took place rather slowly, and chaotically, as well.[11]

The impact of rural reform, therefore, is two-fold. First, the dissipation of pre-reform collective programs has left "family support" as the primary source of one's old-age security. As rural per capita income grew from 134 yuan a year in 1978 to 463 yuan in 1987[12], many families have become better able to provide for their aged than before. Meanwhile, peasants have begun to consider the government's family planning policy of limiting each young couple to having only one child until the year 2000, as a threat to their old-age security.[13] Secondly, some local governments and communities have developed new sources of old-age support in response to the social consequences of rural reform.

Locally Initiated New Sources of Old-Age Support. In regions where the rural economy has prospered, new sources of retirement income have emerged, primarily out of local initiatives. Understandably, the regions that benefited the most from economic reforms have made the best adjustment in elderly welfare. Rural suburbs of large cities such as Shanghai, Beijing, Tianjin and others have been especially active. They have proved rather innovative in developing a new environment. Some villages and township governments have resorted to seeking philanthropic "contributions", levying special assessments, and using a household income tax and business taxes to fund new and old programs for the elderly, such as retirement pensions for peasants, old-age homes for the indigent elderly with no surviving family members, and the Five Guarantees. Others explored insurance for retirement and health care with the People's Insurance Company of China (PICC), the only insurance corporation in the country.[14]

These are new sources of old-age support that did not exist in the pre-reform period. At present, these locally-initiated programs are very much encouraged by the central government; they are touted as a model because they are funded by peasants themselves, and because they seem to serve as substitutes for family support for the rural population, thus easing the anxiety created by the birth control policy and the breakup of the commune. The population covered by these new schemes remains very small, however. Skeptics also question the administrative and financial stability and integrity of such programs in the long term, especially in times of economic adversity.[15]

Further, the success of rural economic reform is uneven at best, and elderly beneficiaries of rural prosperity are few and far between. In 1986, there were only 26,678 old-age homes sheltering 255,453 elderly. According to the latest count of co-insurance schemes, old-age pensions now exist in 7,000 villages out of 94,000 nationwide. Elderly recipients of the rural Five Guarantees numbered about 2.5 million in 1986. Although the number of elderly in old-age homes has almost tripled since 1980, that of recipients of the Five Guarantees has actually declined somewhat.[16]

Central Government Proposal. What are the government's policies to remedy the social consequences of economic disparity in rural regions? Several years have elapsed as the central government let village and township authorities resolve these problems on their own. Finally, in 1987, the Ministry of Civil Affairs, which has the oversight and policy development responsibility over urban and rural welfare, drafted a proposal to remedy the economic disparity in rural regions. It proposed that in the well-to-do regions, rural enterprises and central government would subsidize peasants for setting up savings cooperatives and welfare facilities, etc. Only in "hardship" regions will local and central government shoulder the entire cost of social welfare.[17] This 1987 proposal, which was subsequently approved by the State Council, was merely a policy statement. The actual implementation still depends very much on the resourcefulness of local administrators in collaboration with the central government.

The Urban Sector

In contrast to the relative ease of the breakup of the rural "iron rice bowl," progress in weaning employees in the state sector and large urban collectives from their dependence on the pre-reform government programs has been slow and tortuous. Many difficulties remain virtually unresolved. Some advances have been made, however, in expanding the urban work force outside the state sector, and developing new sources of support for their old-age security.

Urban Reforms and Their Impact on Social Programs: State-Sector Social Insurance Strengthened. One of the government's modernization aims in 1978 was to retire older workers in the state sector, including government and party cadres. The state-sector employees were entitled to extensive old-age benefits before the 1978 reform. Since then, the government has made further improvements in retirement benefits. In June 1978, the government amended the retirement regulations to enforce the mandatory retirement provision for men to retire at age 60 and women at age 55, or 50 for blue-collar female workers. It intended to remove the estimated 2.6 million older workers from the work force and to hire urban unemployed youths. The new policy had the added advantage of retiring senior employees who might resist modernization initiatives.[18]

To make more older employees retire from the work place, the government also relaxed the eligibility for retirement benefits by reducing the minimum years of service from 20 to 10 years of consecutive service. At the same time, it raised the level of retirement benefits to a range of 60 to 100 percent of pre-retirement wages, depending on length of service and participation in pre-1949 revolutionary wars. To sweeten the pie even further, the 1978 amended provisions stipulated that working age children of retirees could join the state sector to fill the slots, though not necessarily the positions, of their retiring parents.[19]

These policies have been very successful in retiring older workers, but they have had the unforeseen result of rapidly escalating the burden of retirement pay. In 1978, there were three million retirees from the state and urban collective sectors as a whole; in 1985, there were 16 million. The state alone had 11.7 million retirees in 1985. Expenditures for retirement benefits in the state sector rose from 1.7 billion yuan in 1978 to 14.5 billion yuan in 1985.[20]

The sudden increase of retirees has, in the case of state enterprises, also proved to be counterproductive to the overall goal of improving labor productivity. As mentioned earlier, since the abolition of trade unions during the Cultural Revolution period, the work units have taken over the administration and financing of the so-called social insurance programs. In some older industries (e.g., textile), where a large proportion of workers are women who can begin to retire at 50 or 55, many have done so. Some of these enterprises claim that the number of retired workers has outstripped the total of active workers. The work units are faced with unprecedented demands to process retirement claims while the remaining active workers are drafted to devote time and energy to provide the necessary services to retirees rather than to contribute to production. Work units often provide services to retirees in addition to retirement pay. Some organize various activities for their older workers in order to help them ease into retirement, such as setting up employer-sponsored senior centers, organizing retirement clubs or volunteer groups or answering complaints.[21]

State Enterprises and the Economic Responsibility System. The work units' responsibility to finance retiree benefits also proved troublesome for some of the state enterprises that have adopted the economic responsibility system. In the early 1980s the government tried to introduce an economic responsibility system in urban industries to make these enterprises accountable for their own profits and losses. Enterprises adopting the system would retain their own profits above and beyond a quota of the production to be submitted to the state. The purpose, as in the rural economic reform, was to improve labor productivity and reduce dependence on the state. This move, however, has made enterprises adopting the system more aware of their own production costs and expenditures, including the cost of labor insurance programs. Retirement benefits are financed as part of the operating cost before tax and profit. Some financially successful, relatively new enterprises that have few retirees have reportedly increased benefit payments to their retired workers. Some, however, have resorted to cutbacks of retirement and health benefits when profits are low or non-existent.

In older industries, where the number of retired workers makes up a large proportion of all workers, the huge amount in retirement pay often precluded any prospect of profits and, therefore, discouraged employees from working hard.[22] To the extent that state enterprises adopted the economic responsibility system, and to the extent that shortfalls of labor insurance programs are no longer subsidized by the People's Bank but by the enterprises themselves, these programs become dependent on the financial and administrative resources of these establishments. In effect, the labor insurance programs cease to be based on the principles of social insurance and instead take on characteristics of employer-liability programs.

Locally-Initiated Resource Pooling for State Enterprises. To counteract these problems, an increasing but still limited number of local governments (at the county, municipal or provincial level) now experiment with resource pooling along industry lines or on a regional basis. Resource pooling began in 1984 in isolated cities and counties in Jiangsu, Guangdong, and Liaoning provinces. These experiments are voluntary arrangements that began with enterprises within the same industries, but have slowly cut across industry lines with resource pooling among financially better and worse off industries. This is usually achieved with local governments subsidizing the costs.

One central government official claimed in early 1987 that some 600 cities and counties, or one-fourth of all cities and counties, adopted resource pooling for labor insurance. Because the participation in resource pooling is voluntary, the implementation of such programs by a county, municipal, or provincial government in its respective jurisdiction is not necessarily universal.[23] These local experiments reflect the lack of a uniform standard in the administrative and funding practices of the state-sector labor insurance programs, but they also testify to the resourcefulness and responsiveness of some enterprises and local governments to the changing environment, in the absence of comprehensive, integrated national programs and supervision.

State Enterprise Contract Workers. In 1982, in order to streamline the state sector and promote employment by merit, the government introduced measures to gradually move away from "life tenure" in state enterprises and to hire new workers on a fixed-term contractual basis. These workers are hired from a pool of youth entering the labor force for the first time, the urban unemployed, and rural migrants, for example. At present, there are 7.26 million contract workers and they make up about 7.5 percent of the state sector employees. (See Table 1 above)

In 1986, the Provisional Regulations for Contract Workers in state enterprises introduced, for the first time, the principle of contribution by employees themselves to social security. These regulations stipulated that contract workers hired by the state sector after September 1986 help pay for social security costs. They provide the contract workers the same level of medical care as permanent workers. Local governments were directed to create separate, locally administered retirement pension funds, contributed by employers at no more than 15 percent of the payroll and by employees at about 3 percent of wages. The requirement of contributions by employees themselves represents a radical departure from the past, even though employees only contribute about one-sixth of total costs. Only time will tell how successful this policy is and whether it can be gradually carried over to permanent workers of state enterprises. As is often the case in China, the promulgation of these regulations is merely a statement of policy or an objective that is not necessarily ready for general (or widespread) implementation. The regulations included the proviso that implementing procedures were to be developed by local governments.[24] To date, enterprise implementation of these regulations has been very limited.

People's Insurance Company of China (PICC) and Old-Age Support. As a result of the government's policy to encourage employment outside the state sector, there has emerged a growing number of workers in small collectives and private enterprises in cities and towns. As of 1987, they totaled about 17 million (one-third of employees in urban collectives and all workers in the private sector). These workers are not covered by the state-sector labor insurance system. In recent years, however, the People's Insurance Company of China has moved in to provide voluntary retirement and health plans for individuals and groups. The total number of these workers participating in these plans is very limited. According to the PICC annual report, the number of all insured persons for retirement, presumably including both rural and urban residents, reached only 3.75 million in 1986.[25]

Central Government Policies. The central government generally adhered to the approach of guaranteeing state-sector employee programs while leaving the non-state sector to ad hoc, local initiatives. The Ministry of Labor, which has the oversight and policy development of the enterprise social insurance programs, has generally adhered to its mandate of following a hands-off approach and allowed local governments a free rein in developing their own experiments. Given the widely divergent patterns of personnel make-up and financial resources of different enterprises, one may well argue that the freedom to experiment locally has allowed individual enterprises to develop their own balancing acts of improving labor productivity of active workers without undermining income security for retirees. Presumably, to the extent that many state enterprises continue to rely on the People's Bank to rescue them from financial troubles, and to reimburse their operating costs (including expenses for retirement benefits), the funding of social insurance is secure, and the economic dependence of the urban work force on the state sector remains unshaken.

The Seventh Five-Year Plan

The Seventh Five-Year Plan pledges the development of a social security system by the year 1990, according to established guidelines. Viewed in retrospect, these guidelines can be read as statements espousing the status quo, rather than proposing bold initiatives to revamp existing programs. So far, the government has adhered to the principle of developing programs that are affordable and compatible with local conditions. In both rural and urban areas, the central government's attempts to refashion social security have been very limited, thus allowing local communities and governments to devise ad hoc experiments depending on availability of their own resources.

The existing programs may be seen as parts of a "multi-layered" social security system covering different segments of the population. For the rural sector, the State Council has already approved the general principle of a three-directional approach to social security according to each region's stage of economic development. For the urban labor force, banning dramatic advances in economic reforms, the state-sector employees are likely to continue their entitlement to extensive benefits financed by the government. Meanwhile, the growing number of workers for small urban collectives and private enterprises has only limited recourse to voluntary pension policies. For the great majority of the rural population and an expanding segment of urban population, family support has become the all-important source of old-age security.

Shifts of social security funding from government to other sources have occurred in some cases. The state-sector social insurance for contract workers has, for the first time, introduced employee contributions to pension finance. The People's Insurance Company of China is offering, to both rural and urban populations, voluntary individual and group pension and health plans with policy holders paying premiums. In the countryside, the traditional networks of family, relatives and neighbors have taken on the bulk of the responsibility for old-age security in the absence of communal welfare funds.

Conclusions

In the last 10 years, sources of old-age support for the rural population have shifted markedly. The government's modernization initiatives and its efforts to wean the population from heavy dependence on collective and state support have been rather successful in the countryside due to swift changes made in agricultural reform and the abolition of rural communes. The family replaced communes as the primary source of protection for the rural population. Unfortunately, the rural indigent who have no families are left with rather limited-sources for old-age security and welfare.

New forms of income protection offering retirement pensions and old-age insurance policies have appeared in some economically prosperous regions, where local administrators are energetic and resourceful. The availability of these programs, however, is uneven and the programs themselves have not sufficiently withstood the test of time. The Ministry of Civil Affair's 1987 proposal for rural communities and governments to set up different types of social security programs according to the level of local economic development merely reflects the government's stated policy, as yet to be implemented. The poor, disabled, or less resourceful families who cannot compete successfully in the new economic environment in well-off regions, and those in the underdeveloped regions in western and some central provinces, have not been able to share the fruits of economic success of the agricultural reforms.

In the urban sector, the government's attempts to break the "iron rice bowl" have not made much progress. The state-sector social insurance programs, which provide rather generous benefits to about 90 percent of the urban labor force, for the most part, have remained intact. For older workers, the benefit level has risen and caused a heavy burden for the national economy. Employee contributions to old-age pensions have been introduced to only the newly-employed contract workers in the state sector and awaits implementation in most locales.

In 1986, the government announced, in the Seventh Five-Year Plan, its commitment to develop a new social security system compatible with the new economic environment by 1990. The stated general guidelines for the proposed scheme, however, could be read as policy statements espousing the current system -- one that is loosely structured, consists of variegated programs for different segments of the population, and one that allows ad hoc, locally initiated adjustments to respond to challenges posed by economic reforms. At present, as PRC leaders are busily reassessing the pace and direction of their economic modernization initiatives, major departure from the existing system is not likely to occur in the near future.

RECENT SOCIAL SECURITY POLICIES AND DEVELOPMENTS
IN THE PEOPLE'S REPUBLIC OF CHINA

Endnotes

1. For a summary review and analysis of China's economic reforms, see Dwight H. Perkins, "Reforming China's Economic system," *Journal of Economic Literature* 26 (June 1988): 601-644.

2. National Economic and Social Development: The Seventh Five-Year Plan, 1986-1990 (Guomin Jingji he Shehui Fazhan Dichige Wunian Jihua), Beijing, 1985, pp. 193-195.

3. For other papers on old-age in China presented at the Asia-U.S. Conference on Social Services and Aging Policies, Pensacola, Florida, August 8-11, 1988, see Jersey Liang, "Long-Term Care for the Elderly in China," for health care for the aged in post-reform China; Chang-Hua Wang, "Retirement Policy, Health and Social Services for the Elderly in Shanghai;" and Wen-hui Tsai, "Welfare Policies for the Aged on Both Sides of the Taiwan Strait." For discussions of social security programs relating to disability and survivors insurance, cash sickness benefits and medical care, and workers' compensation, see Lillian Liu, "Recent Social Security Developments in the People's Republic of China," *Social Security Bulletin*, 50 (April, 1987): 75-78.

4. Zhongguo Nongcun Tongji Nianjian (Chinese Rural Statistical Yearbook, hereafter Nongcun), Beijing, 1987, p. 266. According to statistics available for 1985 and 1986, over 82 percent of recipients of Five Guarantees were aged, almost 14 percent were disabled, and the rest were orphans.

5. Jianzhong Tang and Laurence J.C. MA, "Evolution of Urban Collective Enterprises in China," *China Quarterly 104* (December 1985): 615.

6. "State-sector social insurance" is used here to include all programs established by regulations and directives to provide cash and in-kind benefits to employees in the state sector, be they workers of state enterprises, professors of universities, or government and party cadres.

The 1951 Provisional Labor Insurance Regulations, as amended in 1953 and later supplemented by the 1958 Provisional Regulations (Draft) Regarding the Retirement of Workers, served as the basic documents that governed social security programs for state enterprise workers.

The 1958 "Provisional Retirement Regulations," together with at least five other separate "regulations," "directives" or "provisional procedures," provided old-age pensions and benefits for cash sickness, medical care and work injury for employees in government and party organizations (including scientific, educational and cultural institutions).

For additional details, see Kezhong Wang, et al; Dangdai Zhongguo de Zhigong Gongzi Fuli he Shehui Baoxian (Wage, Benefits, and Social Insurance of Workers and Employees in Contemporary China), Beijing, 1987, pp. 302-318. For the most recent, detailed treatment in English on programs for state enterprise workers see, Nelson W.S. Chow's *The Administration and Financing of Social Security in China*, Hong Kong, 1988, pp. 16-28, 87-92.

7. Wang, p. 322. The "up to three-fifths" is a rough estimate at best for two reasons. First, there is the lack of data. I have not been successful in finding any source that gives a specific breakdown of insured persons by sector of employment, state or collective, for any given year or time period before 1978. Secondly, the number of urban collective employees who were entitled to the same level of benefits as their peers in the state sector presumably fluctuated as the status of the so-called "large urban collectives" changed, over time, from the "State-sector" to the "collective sector", and vice versa. See Tang, Ma, pp. 614-640.

The estimate of about three-fifths of urban collective workers during the pre-1978 period is made from information available during the 1980s. According to Zhongguo Shehui Tongju Ziliao(Chinese Social Statistical Material), hereafter, Zhongguo, Beijing, 1987, p. 112, the total number of insured urban collective workers was 22.35 million in 1985, more than two-thirds of the total work force (33.24 million) in these collectively-owned units in the same year. Deborah Davis-Friedmann of Yale University estimated that only "20 to 30 percent of these collectively owned *units* (emphasis mine) were large, profit-making enterprises with welfare benefits comparable to those paid state workers" in her "Chinese Retirement: Policy and Practice," in *Current Perspectives on Aging and the Life Cycle*, Vol. 1 (1985), p. 311. She did not specify, however, the proportion of workers in these large collectives relative to workers in all urban collectives.

I have referred elsewhere to a special program outside the state-sector plans, established in 1966, for urban collectives under the jurisdiction of the Second Ministry of Light Industries. See Lillian Liu, "Mandatory retirement and other Reforms Pose new Challenges for China's Government," *Aging and Work*, 5 (1982):122. This program offered retirement benefits at a level lower than the state-sector plans, and it provided no cash benefits for sickness and maternity or medical care coverage. It should be noted, however, that the program was promulgated on the eve of the Cultural Revolution, which marked a decade (1966-1976) of rampant disruption at all levels of government and society. Also, the findings by Tang and Ma revealed the fluctuating status and jurisdiction of the Second Ministry of Light Industry. Until concrete information is available, it is very difficult to estimate the number of workers covered by the program, if indeed it were implemented with any degree of stability and accountability.

8. See especially Article 2 (1) and (2), Article 4 (4), and Article 12 of the 1958 State Council's "Provisional Regulations Regarding Retirement of Workers and Employees Guanyu Gongren, Zheyuan tuixiu

Culi de Zhanxing Guiding);" and Articles 8, 9 and 11 of the 1953 "Labor Insurance Regulations (Laodong baoxian tiaoli)." Laodong Gongzhi Wenjian Xuanbian (Selected Documents of Labor and Wages), Fujian 1973, pp. 276-277, 407-408, 410; Davis-Friedmann, p. 300.

9. Wang, p. 324; Huijuan Feng, "Woguo Tuixiu Zhigong Duiwu de Bianhua he Tuixiu Zhidu de Yange (Changes in the Ranks of China's Retired Workers and the Development of the Retirement System)", Zhongguo Laodong Kexue (Chinese Labor Science) (hereafter ZLK), 9 (1986): 23-25. According to rough estimates reported by the author, there were about 20,000 retired workers in 1952, 100,000 in 1966, and 314,000 in 1978. Ibid, p. 23.

10. Wang, pp. 323-324; Deborah Davis, "Unequal Chances, Unequal Outcomes: Pension Reform and Urban Inequality," *China Quarterly*, 114 (June 1988): 237-238; and Davis-Friedmann, p. 302.

11. William H. Hinton, "A Trip to Fengyang County: Investigating China's New Family Contract System." *Monthly Review* 35 (November 1983): 1-28; Shuhe Liu, "Biange Zhong de Nongcun Yanglao Shiye (Rural Programs for Old-Age Support under Reforms)" *Shehui Xue yu Shehui Kexue (Sociology and Social Sciences)*, 3 (1987): 44-50. Judith Banister, China: Recent Trends in Health and Mortality, Washington, D.C., U.S. Bureau of the Census, 1986, pp. 12-18.

12. *China: Statistics Abstract*, 1988, Beijing, 1988, p. 99.

13. The need for family support in old age is not the only reason why rural inhabitants resist the government's birth control policy. Cultural heritage aside, peasants now want more children, especially male children because they can help in field work and increase family income.

14. Hinton, pp. 1-28; Bing Wang, "Nongmin Yanglao Baoxian Tantao (Explorations of Rural Old-Age Insurance)" *Renkou Kexue (Demo-*

graphic Science) 2 (1986): 33-41: Shengzhu Gu, "Nongcun Yanglao Fangshi Chutan (Preliminary Investigations of Different Forms of Rural Old-Age Support)" *Renkou Kexui (Demographic Science)* 2 (1986): 29-33; Chingxiang Liu, "Luetan Fazhan Liaoning Nongcun Yanglao Shiye de Jige Wenti (On Problems of Developing Rural Old-Age Support Programs in Liaoning)" *Renkou Diaocha yu Yenjiu (Population Surveys and Research)* 1 (1985): 28-33.

15. One 1987 source estimated that about 4 million (or 5.4 percent) of the rural elderly (aged 60 and over) benefited from some form of social security. See Guiming Wu, "Jingji Tixi Gaige yu Shehui Baozhang (Economic System Reform and Social Security)" *Shehuixue yu Shehui Diaocha (Sociology and Social Surveys)* 2 (1987): 48.

16. Nongcun, 1985, pp. 282, and 285, and Nongcun, 1987, pp. 266 and 269. For distribution of Five Guarantees recipients by province, see Nogcun, 1987, p. 268. For a vivid example of impoverished lives of childless elderly amidst the land of plenty, see a report about the old-age support system in a village in Shaoxing county, Zhejiang Province by Ganggang Zheng, "Nongcun laonianren Shehui Baozhang Zhengyi (Debates on Rural Elderly and Social Security)" *Shehuizue yu Shehui Daiocha (Social Sciences and Social Surveys)* 1 (1987): 50. In 1986, per capita annual income in that village was 3,000 yuan. The 12 childless elderly in the same village, however, had to subsist on 80 to 120 yuan a year.

17. Chow, pp. 81-83. The proportional sizes of population residing in "well-to-do, "developing regions", and "underdeveloped regions" throughout China are not readily apparent. A 1986 article reported that the Ministry of Civil Affairs considered that about 60 percent of the 2,132 counties nationwide were poverty stricken regions "pinkun qu". Generally speaking, these areas were located in mountainous and hilly areas, lacking natural resources, and providing a low level of education and development. "Pinkun Diqu de Han-i he Fenglei (The Definition and Classification of Poverty-Stricken Regions)" *Nongye Jingji Wenti (Problems of Agricultural Economy)* 8 (1986): 14, 22-24.

18. For the political implications of the government's retirement policy, i.e., removal of the elderly senior officials from decision making positions, see Wen-hui Tsai, "Life After Retirement: Elderly Welfare in China, "*Asian Survey* 27 (May 1987): 42-57.

19. See the State Council's June 1978 "Provisional Procedures for Retirement and Disability of Workers (Gongren Tuixiu, Tuizhe de Zhanxing Banfa)," in Shehui, Wenjiao, Xinzheng, Caiwu Zhidu Zhaibian (Excerpts on the System of Social, Cultural and Educational Administration and Finance), Beijing, 1979, pp. 426-436; Davis-Friedman, p. 301. See also, Davis, pp. 233-237, for a recent, detailed discussion on the policy of employing the retirees' offspring in the state sector.

20. The total number of employees covered under these programs made up about 90 percent of urban workers, about 89 million in 1978 and 113 million as of 1985. The total number of retirees includes those who leave the work force on disability (tuizhi) at age 50 (men) or 45 (women). Retirement benefit expenditures also include disability benefits. See Zhongguo, p. 111, 114-115. See also, Davis, pp. 228-230.

21. Shi-an Pei, "Guanyu Gaige Tuixiujin Zhidu de Sikao (Considerations Regarding the Reform of Retirement Pension System)" *Jingji yu Guanli Yenjui (Economics and Management Research)* 5 (1986): 36-38; Huazhang Feng,"Shanghaishi Quanmin Suoyouzhi Chiye Shexing Tuixiufei Togchou de Qingkuang (The Implemention of Resource Pooling in State-sector Enterprises in Shanghai Municipality)", ZLK 6 (1987): 12.

22. Pei, Ibid, p.36.

23. Huazhong Fu,"Guanyu Zhigong Tuixiu Feyong Shehui Tongchou Wenti (Issues Concerning Resource Pooling for Financing Retired

Workers' Benefit Expenditures)", ZLK, 6 (1987): 9-11; Changlin Pan, "Qiantan Zhigun Tuixiujin de Tungchou Wenti (Preliminary Discussions on Problems of Resource Pooling for Employee Retirement Funds)" *Caiwu yu Kuaiji (Finance and Accounting)* 3 (1987): 43. Until summer 1988, Mr. Fu was the Director of the Bureau of Labor Insurance and Welfare, Ministry of Labor and Personnel. See also, Davis, pp. 238-240.

24. For the complete text of the Regulations see Renmin Ribao (People's Daily), September 10, 1986, p. 2.

Taizhou city of Jiangsu province has reported its efforts of devising a record-keeping system for contract workers to be administered by enterprises and the municipal social insurance office. Taizhou was also the pioneer in developing resource pooling for enterprises in 1984. See, "Wansahan Laodong Hetongzhi Gongren Laodong Baoxian Zhidu de Tansou (Attempts to Improve the Labor Insurance System for Contract Workers)', ZLK 3 (1988): 48.

25. The People's Insurance Company of China. Reports and Accounts for the Year Ended 31st December 1986, Beijing, 1987, p. 6.

Selected Bibliography

Banister, Judith. China: Recent Trends in Health and Mortality. Washington, D.C., U.S. Bureau of the Census, 1986.

China: Statistics Abstract. 1988. Beijing, 1988.

Chow, Nelson W.S. The Administration and Financing of Social Security in China. Hong Kong, 1988.

Davis, Deborah. "Unequal Chances, Unequal Outcomes: Pension Reform and Urban Inequality", China Quarterly 114 (June 1988): 223-242.

Davis-Friedmann, Deborah. "Chinese Retirement: Policy and Practice", in Current Perspectives on Aging and the Life Cycle 1 (1985): 295-331.

Feng, Huazhang, "Shanghaishi Quanmin Suoyouzhi Chiye Shexing Tuixiufei Togchou de Qingkuang (The Implementation of Resource Pooling in state-sector Enterprises in Shanghai Municipality)", Zhongguo Laodong Kexue (Chinese Labor Science) 6 (1987): 12-15.

Feng, Huijuan. "Woguo Tuixiu Zhigong Duiwu de Bianhua he Tuixiu Zhidu de Yange (Changes in the Ranks of China's Retired Workers and the Development of the Retirement System)", Zhongguo Laodong Kexue (Chinese Labor Science) 9 (1986): 23-25.

Fu, Huazhong. "Guanyu Zhigong Tuixiu Feyong Shehui Tongchou Wenti (Issues Concerning Resource Pooling for Financing Retired Workers' Benefit Expenditures)", Zhongguo Laodong Kexue (Chinese Labor Science), 6 (1987): 9-11.

Gu, Shengzhu. "Nongcun Yanglao Fangshi Chutan (Preliminary Investigations of Different Forms of Rural Old-Age Support)", Renkou Kexui (Demographic Science) 2 (1986): 29-33.

Hinton, William H. "A Trip to Fengyang County: Investigating China's New Family Contract System", Monthly Review 35 (November 1983): 1-28.

Laodong Gongzhi Wenjian Xuanbian (Selected Documents of Labor and Wages). Fujian, 1973.

Liang, Jersey. "Long-term Care for the Elderly in China". Paper presented at the Asia-U.S. Conference on Social Services and Aging Policies, Pensacola, Florida, August 8-11, 1988.

Liu, Chingxiang. "Luetan Fazhan Liaoning Nongcun Yanglao Shiye de Jige Wenti (On Problems of Developing Rural Old-Age Support Programs in Liaoning)", Renkou Diaocha ye Yenjiu (Population Surveys and Research) 1 (1985): 28-33.

Liu, Lillian. "Mandatory Retirement and Other Reforms Pose New Challenges for China's Government", Aging and Work 5 (1982): 75-78.

______________. "Recent Social Security Developments in the People's Republic of China", Social Security Bulletin 50 (April, 1987): 75-78.

Liu, Shuhe. "Biange Zhong de Nongcun Yanglao Shiye (Rural Programs for Old-Age Support Under Reforms)" Shehui Xue yu Shehui Kexue (Sociology and Social Sciences) 3 (1987) : 44-50.

National Economic and Social Development: The Seventh Five-Year Plan, 1986-1990 (Guomin Jingji he Shehui Fazhan Dichige Wunian Jihua). Beijing, 1985.

Pan, Changlin. "Qiantan Zhigun Tuixiujin de Tungchou Wenti (Preliminary Discussions on Problems of Resource Pooling for Employee Retirement Funds)" Caiwu yu Kuaiji (Finance and Accounting) 3 (1987): 43.

Pei, Shi-an. "Guanyu Gaige Tuixiujin Zhidu de Sikao (Considerations Regarding the Reform of Retirement Pension System)" Jingji yu Guanli Yenjiu (Economics and Management Research) 5 (1986): 36-38.

The People's Insurance Company of China. Reports and Accounts for the Year Ended 31st December 1986. Beijing, 1987.

Perkins, Dwight H. "Reforming China's Economic System", Journal of Economic Literature 26 (June 1988): 601-644.

"Pinkun Dique de Han-i he Fenglei (The Definition and Classification of Poverty-Stricken Regions)" Nongye Jingji Wenti (Problems of Agricultural Economy) 8 (1986): 14, 22-24.

Renmin Ribao (People's Daily), September 10, 1986, p. 2.

Shehui, Wenjiao, Xinzheng, Caiwu Zhidu Zhaibian (Excerpts on the System of Social, Cultural and Educational Administration and Finance). Beijing, 1979.

Tang, Jianzhong, and Laurence J.C. Ma. "Evolution of Urban Collective Enterprises in China", China Quarterly 104 (December 1985): 614-640.

Tsai, Wen-hui. "Life After Retirement: Elderly Welfare in China", Asian Survey 27 (May 1987): 42-57.

---------------------. "Welfare Policies for the Aged on Both Sides of the Taiwan Strait". Paper presented at the Asia-U.S. Conference on Social Services and Aging Policies, Pensacola, Florida August 8-11, 1988.

Wang, Bing. "Nongmin Yanglao Baoxian Tantao (Explorations of Rural Old-Age Insurance)" Renkou Kexue (Demographic Science) 2 (1986): 33-41.

Wang, Changhwa. "Retirement Policy, Health and Social Services for the Elderly in Shanghai". Paper presented at the Asia-U.S. Conference on Social Services and Aging Policies, Pensacola, Florida, August 8-11, 1988.

Wang, Kezhong, et al. Dangdai Zhongguo de Zhigong Gongzi Fuli he Shehui Baoxian (Wage, Benefits, and Social Insurance of Workers and Employees in Contemporary China). Beijing, 1987.

"Wansahan Laodong Hetongzhi Gongren Laodong Baoxian Zhidu de Tansuo (Attempts to Improve the Labor Insurance System for Contract Workers)", Zhongguo Laodong Kexue (Chinese Labor Science) 3, (1988): 48.

Wu, Guiming. "Jingji Tixi Gaige ye Shehui Baozhang (Economic System Reform and Social Security)" Shehuixue yu Shehui Diaocha (Sociology and Social Surveys) 2 (1987): 47-48, and 64.

Zheng, Ganggang. "Nongcun Laonianren Shehui Baozhang Zhengyi (Debates on Social Security for the Rural Elderly)" Shehuixue yu Shehui Diaocha (Social Sciences and Social Surveys) 1 (1987): 50-52.

Zhongguo Shehui Tongji Ziliao (Chinese Social Statistical Material). Beijing, 1987.

Zhongguo Nongcun Tongji Nianjian (Chinese Rural Statistical Yearbook). Beijing, 1987.

CHAPTER 2

LONG-TERM CARE FOR THE ELDERLY IN CHINA

Jersey Liang
and
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Introduction

Constituting nearly a quarter of the human race, the population of China also has the largest number of older people (aged 65 and over) of any country in the world. The recent decline in fertility has greatly accelerated the aging of the Chinese population. As a result, the demand for long-term care is expected to increase substantially. This chapter provides a factual assessment of the system of long-term care for the elderly in the People's Republic of China. Specifically, the aging of the Chinese population and its implications are discussed first. Second, health conditions of the Chinese aged and demand for long-term care are examined. Third, the system of long-term care in China with respect to its organization and financing is presented. Finally, policy issues related to long-term care are reviewed.

Population Aging in China

China has a total population of more than one billion which constitutes 22% of the world's population. With a per capita gross national product of $281 in 1982, China ranks in the bottom third of the developing nations (World Bank Atlas, 1983). Given that the proportion of population aged 65 and over in the world was 5.8% in 1980, China has a relatively young population. In 1953, about 25 million persons, 4.4% of the total population in China, were 65 and over. This age group grew to over 49 million persons in 1982, accounting for 4.9% of China's population (Table 1). If one defines old age as 60 years of age or older, China had an older population of about 42 million people, 7.3% of the total population in 1953. This group numbered 76.6 million persons or 7.6% of the total population in 1982. Between 1953 and 1982, the 60 and over population grew at an annual rate of 2.14% while the total population increased at a rate of 2% per year.

Table 1.
Age Structures of China in 1952, 1964, and 1982

	1953		1964		1982	
Age	Numbers in 1000	%	Numbers in 1000	%	Numbers in 1000	%
0-14	206,845	35.67	281,650	40.53	337,251	33.45
15-64	347,558	59.94	388,608	55.92	621,506	61.65
65 and over	25,401	4.38	24,687	3.55	49,366	4.89
Total	589,804	100.00	694,944	100.00	1,008,123	100.00
60 and over	42,142	7.27	42,427	6.10	76,749	7.61

Source: Coale, A.J., *Rapid Population Changes in China. 1952-1982*. National Academy Press, Washington, D.C., 1984.

Of the total population aged 60 and over in 1982, 35.7% were 60 to 64 years old; 27.7% were 65 to 69 years old; 18.7% were 70 to 74 years of age; 11.3% were 75 to 79 years old; and 6.6% were 80 years of age or older. Among those 60 years of age and over, the sex ratio is 87 which is higher than those in the more developed countries but is lower than in other developing countries such as India and Singapore. In China, old people exhibit a profile of marital statuses similar to those in other countries. Specifically, some 70% of older men are married and about 25% are widowed. Only 2.5% of older men have never been married and 1.5% are divorced. For older women, some 40% are married while nearly 60% are widowed. Only 0.3% of older women have never been married and less than 0.5% of them are divorced. In comparison with developed countries, China has much lower rates of singlehood and divorce (Liang, Tu, & Chen, 1986).

The Chinese elderly generally have very little education. Nearly 80% of the aged are illiterate or semi-illiterate. This proportion is more than twice as much as that for the population 12 years of age or older (i.e., 32%). Only some 5% of the elderly have an educational background equivalent to junior high school or more. There are substantial gender and urban vs. rural differences in educational background. While 61% of elderly men are illiterate or semi-illiterate, over 95% of older women belong to those categories. In addition, rural areas exhibit a rate of illiteracy or semi-illiteracy of 82%, which is much higher than its urban counterpart (64%).

Population aging is a result of demographic transition which is a long-term and presumably permanent change from high to low levels of mortality and fertility. In the initial stage, population aging is essentially due to fertility decline. The effect of mortality, particularly mortality reduction in old age, becomes increasingly prominent as the process of demographic transition proceeds. With relatively high fertility and low mortality during most of the 38 years since 1949, China has had a "young" population. Organized fertility control programs began to show their full effects in the 1970s. In 1971, a birth control policy was launched calling for later childbearing, longer spacing, and fewer children. This was succeeded in 1979 by an even more restrictive program: the one-child family campaign under which all married couples are to have one child unless they meet criteria for specific exemptions. As a result, the total fertility dropped from 5.93 births per woman in 1970 to 2.66 births in 1979. By 1984, the total fertility rate further decreased to 1.94, below the level for population replacement (Greenhalgh & Bongaarts, 1987).

Given the rapidly declining fertility, China is expected to have a substantially older population in the middle of the 21st century (Liang et al., 1986). This is especially true if the one-child family policy is successful. According to a number of projections (Banister, 1987; Coale, 1981; Keyfitz, 1984; Liang et al., 1986; Tu & Ting, 1988), the proportion of the Chinese population aged 65 and over is projected to be between 16 and 24 percent by 2030, depending on the underlying assumptions. In numerical terms, the elderly population in China is projected to grow from some 49 million in 1982 to 240 million by 2037, a nearly five-fold increase (Tu & Ting, in press). At the same time, the 80 and over population is projected to increase from 6.1 million or 11% of the 65 and plus population in 1985 to 63.3 million by 2035 or 21% of the older Chinese population (Banister, 1987). As a result of population aging, the demand for long-term care in China is expected to increase substantially.

Health Conditions of the Chinese Aged

In addition to population aging, health conditions of the aged are major determinants of the demand for long-term care (Luce et al., 1983). A brief review of the mortality, morbidity, and disability of the Chinese aged is in order. Life expectancy at birth was about 35 years before 1949. According to Coale (1981), life expectancy in China has increased substantially since 1949. Life expectancy at birth in 1953-1964 was 42.2 years for males and 45.6 years for females. In 1964-1982, it rose to 61.6 years and 63.2 for females. Based on the 1982 census, the 1981 life expectancy at birth in China was 67.9 years: 66.4 years for males and 69.4 for females. At 65, life expectancy is estimated to be 13.6 years. At this age, females are expected to outlive males by 2.16 years. With a median age at death of 67.5 years, the three leading causes of death are heart disease, cerebrovascular disease, and malignant neoplasms, reflecting a pattern of mortalities similar to that of an aging population. This pattern also represents a dramatic shift in causes of death during the past three decades. Respiratory diseases, acute infectious diseases, and tuberculosis were the three leading causes of death in 1957 (Liang et al., 1986).

Although there are no national statistics concerning the prevalence of chronic diseases and disability among the Chinese aged, some rough estimates can be derived from available regional data. According to a review of seven regional studies including both urban and rural elderly, the proportion of aged with chronic diseases ranges from 60% to 82%. With an average of approximately 70% (Gui et al., 1985; Harbin Institute of Social Sciences, 1984; Institute of Population Research, Sichuan Committee on Aging, 1986; Wuhan University, 1986; Qu, 1984; Xu & Wu, 1984; Yuan, 1985).

Since not all elderly people with chronic conditions require long-term care, a better indicator is functional status. As suggested by various regional statistics, between 11% and 15% of the Chinese aged 60 and over suffer some degree of physical disability (Table 2). Among those, some 3 to 5 percent are severely disabled or bedridden. The other 10% have moderate disability (Table 2). These results are somewhat similar to those reported by Nagi (1976) which indicates that about 6% of Americans aged 65 or over need assisted living and have severe limitations in physical and mental performance, and some 11% of elderly Americans need assistance in personal care and mobility. Given that there were some 84 million Chinese aged 60 and over in 1984 (Banister, 1987), and assuming that 14% of them suffered from some physical disability, nearly 12 million elderly Chinese are in need of long-term care. However, this estimate should be interpreted with caution because of the partial coverage of the statistics and the somewhat different criteria in defining disability.

Table 2
Disability Among the Aged
(60 years of age or over), Selected Regions, China

Region	Disability (%) Moderate	Severe	Total	Sample Size
Tianjin[1]	--	--	11	1,098
Shanghai[2]	10	3	13	3,897
Jilin[3]	--	--	15	5,425
Hubei[4]				
Urban	10	4	14	1,425
Rural	11	4	15	2,523

[1] Tian Committee on Aging. (1985). Conditions of the Elderly in Tianjin. Tianjin: Tianjin Committee on Aging.

[2] Cui, S. (1987). Conditons and preferences of the aged in Shanhai. *Journal of East-China Normal College*.

[3] Qu, H. (1984). Status of the Elderly in China. Cairo Demographic Center. *Research Monograph Series, No. 13*, Cairo.

[4] Wuhan University Institute of Population Research. (1986) Survey of the Aged in Hubei Province, Wuhan.

The System of Long-Term Care

China possesses a rather unique configuration of social, political, and demographic characteristics, including a centralized policy-making structure, a strong tradition of family-based old age support, a predominantly rural population, and an emerging private sector. Its long-term care system can be analyzed in three dimensions: (1) clients, (2) sponsoring organizations, and (3) the distinction between urban and rural areas.

For the Chinese elderly, the family is the predominant mode of support. Children have the duty to provide support to their aged parents and violators are subject to criminal penalties. Old people who have no grown children to support them, no capability to work, and no other means of support (i.e., the three-no's elderly) can rely on social welfare. Local governments are responsible for the administration of social welfare for the needy. Since most of the aged on welfare are childless, they are generally referred to as the childless aged.

Long-term care is provided by several types of organizations. These include (1) hospitals, social welfare homes, and convalescent homes for cadres sponsored by the state, (2) homes for the aged, community based long-term care, and primary health stations organized by local communities, (3) long-term care services provided by various large enterprises or employers for their employees, and (4) home care including "home-based sick bed" and support provided by the family.

A thorough understanding of the Chinese long-term care system cannot be reached without taking into account the sharp disparities in economic well-being between rural and urban residents. In 1984, urban income per capita was 608 yuan where rural income per capita was 355 yuan (State Statistical Bureau, 1985a). In addition, substantial differences in terms of fringe benefits and welfare support exist between urban and rural areas (Davis-Friedmann, 1983). Migration from rural areas to urban areas has been strictly controlled.

Table 3 presents an array of long-term care services in terms of the areas, clients, and providers. In the urban areas, long-term care for the childless elderly is provided by social welfare homes and community based long-term care programs. Social welfare homes can be subdivided into two categories: those administered by departments of civil affairs and those managed by urban collectives in cities and towns. Social welfare homes administered by the department of civil affairs (hereafter referred to as city welfare homes) are financed by funds provided through the governmental social welfare trust fund. Other institutions supported by the social welfare trust fund include orphanages and mental institutions. The total number of social welfare homes has increased steadily from 577 in 1978 to 709 in 1983. However, the total number of residents has remained relatively constant between 38,000 and 41,000. In contrast with a per capita annual expenditure of 533 yuan (U.S. $280) in 1978, the annual per capita expenditure stood at 1,402 yuan (U.S. $700) in 1983 (State Statistical Bureau, 1985b).

Table 3
Long-Term Care Services by Areas, Clients, and Sponsoring Organizations

Areas/Clients Organizations	Housing	Nursing care	Meals	House Keeping	Shopping	Primary Health Care	Personal Care	Personal Care (Intermittent)	Rehabilitation	Curative Care
Urban Areas										
For childless aged										
Social welfare homes (Dept of civil affairs)	x	x	x	x	x	x	x		x	
Social welfare homes (City/town collectives)	x	x	x	x	x		x			
Community based long-term care		x		x	x			x		
For aged in general										
Convalescent homes for employees	x	x	x	x	x	x	x		x	x
Hospitals	x	x	x	x	x	x			x	x
Social welfare homes	x	x	x	x	x	x	x		x	
Home-based sick beds		x				x			x	x
Family support	x	x	x	x	x		x			
Rural Areas										
For childless aged										
Homes for the aged	x	x	x	x	x		x		x	
Support by relatives and/or neighbors		x	x	x	x		x	x		
For aged in general										
Primary health care station						x			x	
Rural hospital	x	x		x		x			x	
Family support	x	x	x	x	x		x		x	

Social welfare homes may also be managed by collectives in cities and towns (hereafter referred to as collective welfare homes). They are financed by funds provided by the collectives and state subsidies. In 1985, there were 3,519 collective welfare homes. These homes had a staff of 10,375, a total of 59,461 beds, and a resident population of 47,910 (State Statistical Bureau, 1986). The emergence of this type of home is a relatively recent phenomenon, responding to an increasing demand for long-term care.

In addition to room, board, and a small allowance, all homes offer a range of services including personal care. Primary health care and rehabilitation are, however, likely to be available only at city social welfare homes. In general, city welfare homes involve much more capital investment, and have better facilities and more professional staff than collective welfare homes. They are likely to exist in cities, and in small towns frequently only collective welfare homes are available. As illustrated by data collected in Hubei Province, social welfare homes in large cities are on the average bigger in terms of numbers of beds and residents than those located in smaller cities or towns. Although large-city social welfare homes have a lower average population of impaired residents, they have higher health care staff to resident ratios than homes in other welfare homes in urban areas. Consequently, the average expenditure per resident in city welfare homes has been substantially higher than that in collective welfare homes. For instance, in 1983 the national average expenditure for each resident in city welfare homes was 1,402 yuan, but the average expenditure for a resident in collective homes for the aged in Hubei Province was only 215 yuan in 1985 (Wang & Gu, 1986).

Table 4
Characteristics of Social
Welfare Homes in Urban Hubei, 1985[1]

Characteristics	Large Cities	Middle Size/ Small Cities	Small Towns
Number of homes	9.0	5.0	85.0
Physicians per 100 elderly residents	11.2	2.2	1.6
Nurses per 100 elderly residents	20.6	15.4	14.8
Beds per home	133.6	120.2	45.9
Elderly residents per home	92.3	99.5	38.6
Proportion of elderly residents with impairments	25.2	39.2	27.9

[1] Unpublished survey data collected in Hubei Province, 1986, by B. Wang and S. Gu, Institute of Population Research, Wuhan University.

In urban areas, community based long-term care takes two basic forms. The first involves contracting the care for a given childless and needy elderly person to a team of two or three residents in the neighborhood called nursing groups (Bao-hu zu). These individuals may be either volunteers or be compensated for providing care by the local community. The types of services provided vary depending on the functional level of the childless elderly. For those who are ambulatory, the nursing group looks in on the household regularly to ensure that food and other necessities are available and transportation to the health clinic is provided. For elderly people who are not fully self-sufficient due to physical and mental failings, the nursing group makes daily visits and provides services including shopping, meals, housekeeping transportation, and administering medicines. For those requiring full care, the nursing group provides even more comprehensive services including bathing, cooking, cleaning, and other personal care services. In such cases, the individuals providing the care are usually compensated (Olson, 1987). According to Yuan (1986), some 8,000 persons or 33% of the childless elderly population in Shanghai were served by these community-based long-term care teams. In Hubei Province, there were 2,923 long-term teams caring for 8,194 persons or 32% of the childless aged population.

In addition to the community-based long-term care teams, there are various charities aimed at providing assistance to the childless elderly at regular intervals. Typically these involve the mobilization of students, military personnel, and employees of factories, enterprises, and hospitals by local governments. For instance, in 1984 some 11,300 service-episodes, 575,000 kilos of grain, 1,250 kilos of coal, and 1,600 kilos of vegetables were provided to the childless elderly by employees of the commercial sectors in Huang Pu District, Shanghai City (Yuan, 1986). In addition, housing and repair services were furnished by the department of housing, and students were organized to make regular visits to needy elderly.

In 1986 among the 347,979 childless and needy elderly in the urban areas, 184,743 or 53% were supported by the state welfare programs. Among those, 8% were cared for in social welfare homes; 23% were residents in collective welfare homes; and 69% were supported by community-based services (Chinese Population Information Center, 1986).

As in the urban areas, the childless and needy aged in rural areas can rely on social welfare. Social welfare in rural China takes the form of "five-guarantees" which provide food, clothing, medical care, housing, and burial expenses. In addition, a small cash allowance may be included. In 1983, 2.93 million rural residents were eligible for five guarantees. Of the eligible individuals, 2.84 million were provided five guarantees, a coverage rate of 96%. The average expenditure for each individual support was 122.5 yuan (State Statistical Bureau, 1985b). Among the 2.84 million persons supported in 1983, nearly 2.4 million were elderly.

Long-term care for the childless and needy aged in rural areas takes two basic forms. These needy elderly residents either are cared for in homes of the aged or are maintained in the community by relatives and neighbors. In 1985, there were 23,997 homes for the aged in China with 56,577 staff, 317,277 beds, and 268,432 residents (State Statistical Bureau, 1986). They are supported primarily by rural collectives with state subsidies. In areas where homes for the aged are not available, the childless elderly who are disabled are cared for by neighbors and relatives. In addition to "five guarantees" given to the elderly person, care givers are compensated by the production brigade or village. The average monthly wages for the care givers are between 20 and 30 yuan.

In 1984, 8% of the rural needy elderly were cared for in homes for the aged, and 13% were supported by neighbors or distant relatives in the community (State Statistical Bureau, 1986). Homes for the aged in rural areas are similar to collective welfare homes in urban areas in terms of organization and the types of services provided. However, they tend to be smaller than collective welfare homes. For instance, according to a survey in Hubei Province, the average sizes of collective homes in cities and small towns, and rural homes for the aged are respectively 12.7, 16.9, and 8,4 residents per home (Wang & Gu, 1986). The national average expenditure for maintaining a rural elderly resident in a home for the aged was 433 yuan in 1983 (State Statistical Bureau, 1985b).

In contrast to long-term care for the childless aged, care for the elderly in general always assumes the significant role of family in this process. Accordingly, the family almost always proves to be the primary source of support, whereas, a somewhat secondary role is played by non-family based long-term care providers which include convalescent homes for employees, hospitals, social welfare homes, home-based sick beds, primary health care station, and rural hospitals.

Convalescent homes for employees are supported and managed by state enterprises as well as urban collectives. In 1983, there were 903 convalescent homes in China with a total capacity of 71,850 beds (State Statistical Bureau, 1985b). These homes provide convalescent as well as curative care at no cost to employees. Although social welfare homes predominantly served the childless aged, under some exceptional circumstances they also admit older people with families who cannot be cared for at home.

Hospitals also provide long-term care in the sense that they offer primary, rehabilitative, and curative care to elderly people with chronic illness and/or physical disability. Hospitals, particularly where traditional Chinese medicine is practiced, often provide inpatient services to those who are bedridden and those with chronic illnesses. Many hospitals have established geriatric departments to better serve the elderly. According to statistics in Shanghai, the aged constitute 40% of all hospital patients and one-third of the inpatients.

"Home-based sick beds" are sick beds placed at the patients' homes by medical care organizations. Patients may include those with chronic illnesses, those who need convalescent and rehabilitative care, and those who have difficulties in accessing or being transported to a hospital. According to a recent survey in Tianjin, patients who were treated under the home-based sick beds program were mainly those who suffered from hypertension, heart disease, strokes, chronic bronchitis, diabetes, and terminal cancer. Elderly people (aged 65 and over) account for 62.4% of the patients (Tianjin Public Health Bureau, 1985). Similar findings were reported in Shanghai City and Hubei Province.

A major advantage of home-based sick beds lies in its cost saving. Each bed yields an annual saving of 150 yuan. Reports from Shen Yang and Tianjin, the costs of operating home-based beds are from 36% to 57% lower than those for hospital beds. In 1984, there were 490,000 home-based beds which grew to 831,000 in 1986, at a 30% annual rate of increase. At the same time, home-based sick beds programs are also being extended to rural areas. In 1986, there were 132,000 such beds in rural China (Public Health Ministry, 1985). Home-based sick beds are mostly managed by physicians and sometimes by nurses. Services provided include (1) drug therapy, (2) physical therapy, (3) nutrition, (4) clinical examination, (5) mental health counseling, and (6) traditional Chinese medical treatments including acupuncture and massage.

In the rural areas, long-term care is primarily provided by the family. Family support is frequently supplemented by services provided by village health stations and village doctors (or barefoot doctors). Among the 7.38 million villages in China, 6.48 million or 88% have established primary health stations. There are an estimated 12.8 million village doctors (Ministry of Public Health, 1986).

A village doctor is typically a peasant with a primary school education who receives three to six months of medical training and treats minor diseases including minor injuries, gastro-intestinal illnesses, colds, bronchitis, and the like. The village doctor also administers immunizations and birth control, and oversees other activities carried out by public health workers who are trained and supervised by the village doctor (Hu, 1984).

Each village health station is generally staffed by two or three village doctors. If a patient's illness is too serious for the village doctor to treat, the health station either requests the services of a mobile medical team or refers the patient to the commune or township clinic which usually includes both traditional Chinese and Western-trained doctors, along with nurses who perform minor operations (Hu, 1984). A more serious illness may be further referred to a county hospital. Over one half of all village health stations are privately owned and operated by village doctors; 37% are operated by the village collectives; and 4% are supported by the state (Ministry of Public Health, 1986).

As of 1985, only 268,000 rural and some 68,000 urban aged people resided in old age institutions. There are in addition some 70,000 who are cared for at convalescent homes for the employees (State Statistical Bureau, 1986). Thus, a total of 406,000 Chinese elderly were institutionalized, less one-than half of one percent of the more than 84 million people aged 60 and above nationwide. With the exception of the childless elderly who are supported by community-based long-term care, the overwhelming majority of the nearly 12 million physically dependent Chinese elderly are cared for by their families. For example, among the elderly in Shanghai who are partially dependent in activities of daily living, 58% were cared for by the spouse, 30% by the children, 6% by other relatives, 4% by housekeepers, and 2% by community based services. Among those totally dependent in self care, 48% were cared for by the spouse, 40% by the children, 6% by other relatives and neighbors, 5% by housekeepers, and 1% by community based long-term care (Gui, 1986).

This pattern of support is consistent with the prevailing attitudes toward old age support. According to a survey of the urban aged in Shanghai, 38% of the aged preferred to be cared for by the spouse, 19% by sons or daughters-in-law, 29% by daughters, 3% by grandchildren, 11% by a combination of family members, and only 9% preferred other forms of support (Yuan, 1986). Consequently, it is not surprising that only some 10% of the Chinese aged either live alone or live with unrelated individuals. Whereas between 5 to 20 percent live with their spouses only, approximately 70 to 90 percent live with their children (Table 5). According to a recent survey of the aged in Hubei, the major reasons for residing with children include (1) dependence on children (48%), (2) helping children in household chores (23%), (3) enjoying family life (15%), and (4) housing shortage (14%) (Institute of Population Research, 1986).

Table 5
Living Arrangements of the Chinese
Aged (60 years or over), Selected Regions

	Living Arrangements (%)			
Regions	With Spouse Only	With Children and/or spouse	Alone or Others	Sample Size
Rural Areas				
Hubei[1]	10	77	13	2,523
Shanghai[2]	10	82	8	2,012
Urban Areas				
Shanghai[3]	19	75	6	3,897
Beijing[4]	7	89	4	175
Harbin[5]	5	9	32	570
Shannxi[6]	11	80	9	629
Hubei[1]	20	68	12	1,437

Sources:

[1] Institute of Population Research, Wuhan University, Hubei Aging Survey, 1986.

[2] Population Research Center, Chinese Academy of Social Sciences, Chinese Population Almanac, Social Science Press of China, Beijing, 1986.

[3] Gui, S. and Associates (1986). Analysis of the situation and preference of the aged in Shanghai. Journal of East-China Normal School.

[4] Xu, S. and Wu, Z. A survey of the psychological status of the elderly in Beijing. Newsletter of Psychology.

[5] Harbin Institute of Social Sciences. A Survey of Retired Cadres in Harbin. Studies of Harbin.

[6] Sichuan Committee on Aging. The Aged and Society, Sichuan, 1986.

Old Age Support, Health Care, and Long-Term Care

Given their close relationships with long-term care, the Chinese systems of old-age income maintenance and health care will be briefly outlined first. The roles of the state, enterprise, community, and family in financing long-term care will be discussed next.

Financial support for the Chinese derives primarily from the family whereas pension programs are available only in the urban area. Public assistance plays a very limited role (Liang et al., 1986). There are two major pension programs. One covers employees in the state sector including government and party organizations, educational, cultural, and industrial enterprises (Liu, 1982). Retirement age is 60 for men, 55 for female salaried employees, and 50 for female blue-collar workers. At least 10 years employment in the state sector is required to collect a pension. Pensions may range from 60 to 100% of a worker's last wage depending on length of service and prior participation in revolutionary work. In addition to the pension payment, medical insurance benefits and other supplements received before retirement are included. The administration and financing of pension benefits are the responsibility of individual employing institutions.

The other pension program, legislated in 1966, covers only workers of large urban collectives engaged in light industry and handicrafts. Retirement benefits are less generous than those in the state sector. Benefits are payable on retirement after 20 years of work with 8 years of continuous service and replaces 45-60% of pre-retirement wages (Liu, 1982). The collectives' plan does not include health insurance and there is great variation in benefits among different collectives.

As of 1985, some 124 million workers or 25% of China's labor force (18% in the state sector and 7% in urban collectives) were covered by pension programs (Banister, 1987). In 1981, out of the 18 million persons of retirement age (males aged 60 and over and females age 55 and over) in urban areas, about 8 million or 45% received pensions (Goldstein & Goldstein, 1984). In 1983, the number of urban pensioners increased to 13 million; in 1985 it grew further to 16.4 million (Banister, 1987; State and Statistical Bureau, 1985).

The rural labor force and workers in small urban collectives not covered by a pension program must depend on their adult children for old age support. More than 75% of the work force falls into this category. In 1980, only 180,000 older people, or about 0.4% of all rural elderly, received old-age pensions (Liu, 1982). Recently, there has been significant growth and by the end of 1983, some 600,000 rural elderly people in over 9,000 brigades were reported to have received pensions (Yuan, 1985). As indicated previously, older people who have no grown children to support them, no capability to work, and no other means of support can rely on social welfare.

Health insurance in China essentially takes three forms: government health insurance, labor insurance, and rural cooperative insurance. Introduced in 1951, the Government Insurance Scheme provides free outpatient and inpatient services (excluding hospital meals) to government employees, college teachers, and college students. In general only primary members are covered and the dependents receive no benefit entitlement. This scheme is exclusively financed by the state budget. About 2% of the population is covered by this insurance plan (Hu, 1984). Workers and staff employed in state enterprises with more than 100 employees are insured by the Labor Insurance Scheme. It entitles primary members to free health care for life and their dependents to 50% reimbursement of health care costs. The labor insurance is financed by the enterprise with no individual prepayment by the employee. It is estimated that 10 to 12% of the country's population are covered by Labor Insurance (Hu, 1984). Implementation of the rural cooperative insurance system began in 1968. Cooperative insurance schemes generally take the form of a prepaid medical insurance plan, organized at the production brigade level. Beneficiaries are entitled to free or substantially reimbursable services and drugs at the brigade health station and also at higher level referral units. The cooperative insurance is mainly financed at the household, village, and township levels, higher levels of governments including county, province, and central merely subsidize capital investment.

There are clearly sharp disparities in health care between urban and rural areas. In 1980 there were 3.7 hospital beds per 1000 in urban areas but only 1.5 per 1000 in rural areas. The distribution of physicians is even more uneven with 2.4 per 1000 people in the urban areas and 0.5 per 1000 in the countryside (Hsiao, 1984). In addition, since 1980 the rural health system has undergone substantial changes whereas the urban system has remained intact. Given the general economic reforms, collective financing and popular support for the cooperative medical system have diminished. The proportion of the rural population protected by this system has declined by 50%. In 1984, only 11% of production brigades or villages in Hubei had cooperative medical insurance. People now have the option to pay more out of their own pockets for better medical services. The state also encourages and supports physicians to have private practices by setting up clinics or small-scale hospitals. More than 80,000 doctors were in private practice in China in 1985, an increase of more than 63% over the previous year.

China's long-term care is financed by the state, enterprise, local communities, and family. The state or higher levels of governments support long-term care by underwriting part of the funds for various social welfare programs. It should be noted, however, that welfare services are decentralized to local communities and places of work. Programs supported by the state include the establishment and operation of social welfare homes, homes for the aged, community based long-term care, and hospitals. For instance, the residents in city social welfare homes consist of three categories: (1) survivors or dependents of martyrs (3%), (2) childless and needy aged (88%), and (3) non-childless elderly (9%) (Population Information Center, 1986). Costs for caring for the first two categories of elderly residents are entirely born by the state, whereas the third type of elderly residents is supported by a combination of private payment and state subsidies. A survey of 106 non-childless aged residents in Wuhan further revealed the following modes of financing schemes. For 50% of these residents, the costs of care were covered by their own pension incomes; for 28%, the expenses were paid by a combination of individual pensions and subsidies from previous employers; 6% of the residents depended on their former employing units to cover all costs of care; 13% financed the care by personal savings and assistance from their children; and for 3% of the residents, the cost of care was exempted by the social welfare home (Wang & Gu, 1986).

In addition, collective social welfare homes in urban areas and rural homes for the aged are subsidized by the state. In 1983, departments of civil affairs at various levels of government provided 37% of the funds for the operation of rural homes for the aged whereas rural collective welfare trusts provided the remaining 63% (State Statistical Bureau, 1985 b). Finally, through government medical insurance, costs for hospital based long-term care and home-based sick beds are covered.

In China, the work unit (danwei) takes total responsibility for the welfare of the workers and their dependents. Given that the majority of the urban population have become associated with a work unit, either directly through their employers or indirectly through their family members, social welfare is essentially for the childless elderly with no regular employment (Davis-Friedmann, 1983). In many ways, the work unit continues to serve the needs of its retirees. Accordingly, employing units usually provide long-term care through labor insurance and convalescent homes for employees. On the other hand, urban collective welfare homes, rural homes for the aged, and community-based long-term care are essentially the responsibility of local communities which in general cover two-thirds of the expenses, with the state providing the remaining funds.

Policy Implications

Presently, because of the small proportion and relatively young age structure of the older population in China, the needs of long-term care of the aged are being met by the family and to a very limited degree by the state, work unit, and local community. However, in view of the projected sharp increases in the number and proportion of older people, this primarily family based old age support system will be under severe strain. As suggested previously, the percentage of the oldest-old (80 years or above) in China is expected to grow very rapidly (Banister, 1987). This will have profound implications for the demand for health care and long-term care. This is because the aged consume a disproportionate amount of health care resources, particularly during the last year of a person's life (Lubitz & Prihoda, 1984).

In addition, major increases in life expectancy in China have led to the doubling of the average number of person years of an individual's life spent as a grandparent during the past 50 to 60 years (Tu, Liang, & Li, 1987). Thus, the period during which the family bears the burden of old age support is twice as long as before. This is a serious concern given the shrinking average family size. Accordingly, non-family-based old-age support and long-term care should be seriously considered and expanded to reinforce the family-based support. It is possible that an optimal mix of private and public support can be accomplished. This mix will have major implications for containing public expenditures for long-term care.

On the other hand, the impact of China's fertility policy should not be overlooked since there is a direct relationship between fertility level and population aging. As a result of the current one-child birth policy, the absence of siblings and the subsequent loss of other relatives may seriously weaken the family network. According to recent projections, the strict one-child option is least desirable in terms of its effects on population growth, old age support, family economy, and the status of women (Greenhalgh & Bongaarts, 1987). A more optimal strategy may be the two child policies that entail spacing or delaying and spacing. Serious consideration should be given to these alternatives.

Given the close ties between old age income maintenance and long-term care, improvements in the coverage and benefits of pension programs are critical. Pensions are generally only available to workers in the state-sector and large urban collectives. Pension programs are administered and financed by the individual enterprise. This system of retirement pensions is inadequate to meet escalating costs and to ensure the certainty of payment. Currently, a centralized national pension fund for retirees is under study, although some localities are experimenting with the pooling of pension funds (Banister, 1987).

In the rural area, as a result of the recent economic reforms replacing collective farming with a system of household production contracts, the elderly have benefited from increasing prosperity. However, this also has led to setbacks in public assistance programs and in the cooperative medical care system. Many rural residents are reluctant to contribute to local public welfare funds which finance the public assistance and cooperative medical care. In addition, many former village doctors and health workers have opted for more lucrative pursuits in farming and light industry (Liu, 1987). As a result, rural older people now must rely even more heavily on family support than they did before the economic reform.

Because the need for long-term care is often a result of chronic diseases, the development of effective and low-cost strategies for dealing with these disorders is critical. In this regard, the temptation to emulate high cost curative approaches must be resisted; many of these have been proved to be not efficacious and have resulted in a massive drain on national economic resources (Jamison et al., 1984). Although some prevention is relatively difficult for most chronic illnesses, some such measures can be taken, especially with respect to the control of salt intake and tobacco consumption. China has a high incidence of hypertension. This in turn leads to heart disease and strokes which are major public health problems in China today. Tobacco consumption in China has been high and has a direct linkage to increases in lung cancer and chronic respiratory diseases. Consequently, emphasis should be placed upon the development of strategies for prevention of chronic diseases (Jamison et al., 1984).

Substantial inequalities continue to exist between urban and rural areas in terms of economic well-being, health services, and health status. The rural residents not only have a much lower standard of living than their urban counterparts but also have much less access to health care. Although health conditions in the cities are very good, many rural areas lag the cities by 5 to 10 years in life expectancy. Furthermore, the conditions of perhaps 100 to 200 million rural Chinese still remain similar to those in typical developing countries (Jamison et al., 1984). Thus, income maintenance and health care for the rural elderly population deserve special attention.

References

Banister, J. (1987). Implications of the aging of China's population. Paper presented at the International Symposium on Family Structure and Population Aging, Beijing University, Beijing, China, October, 1987.

Chinese Population Information Center (1986). *Population handbook of China,* Beijing: Chinese Population Information Center.

Chinese Population Information Center (1986). *Handbook of population materials, 1986.* Beijing: Chinese Population Information Center.

Coale, A. J. (1981). Population trends, policy, and studies in China. *Population Development Review, 7,* 85-97.

Davis-Freidmann, D. (1983). *Long lives: Chinese elderly and the Communist revolution.* Cambridge, Massachusetts: Harvard University Press,

Goldstein, A. & Goldstein, S. (1984). The challenge of an aging population in the People's Republic of China. Paper presented at the Annual Meeting of the Population Association of America, Minneapolis, Minnesota, May 1984.

Greenhalgh, S. & Bongaarts, J. (1987). Fertility policy in China: Future options. *Science, 235* , 1167-1172.

Gui, S. and Associates (1986). Analysis of the situation and preference of the aged in Shanghai. *Journal of East-China Normal School.*

Harbin Institute of Social Sciences. A Survey of Retired Cadres in Harbin. *Studies of Harbin*, 1984.

Hsiao, W.C. (1984). Transformation of health care in China. *New England Journal of Medicine, 310* , 932-936.

Hu, T.W. (1984). Health services in the People's Republic of China. In M. W. Raffel (Ed.), *Comparative Health Systems.* (pp. 141-152) University Park: Pennsylvania State University Press.

Institute of Population Research, Wuhan University, Hubei Aging Survey, 1986.

Jamison, D.T., Evans, J.R., King, T., Porter, I., Prescott, N., & Prost, A. (1984). *China: The Health Sector.* Washington, D.C.: World Bank.

Keyfitz, N. (1984). The population of China. *Scientific American, 250* , 38-47.

Liang, J., Tu, E.J., & Chen, X. (1986) Population aging in the People's Republic of China. *Social Science and Medicine, 23,* 1353-1362.

Liu, L. (1982). Mandatory retirement and other reforms pose new challenges for China's government. *Aging and Work, 5* , 119-133.

Liu, L. (1987). Recent social security developments in the People's Republic of China. *Social Security Bulletin, 50* , 75-78.

Lubitz, J. & Prihoda, R. (1984). The use and costs of Medicare services in the last two years of life. *Health Care Financing Review*. ACFA Publication No. 03169. Washington, D.C.: U.S. Government Printing Office.

Luce, B., Liu, K., & Manton, K.G. (1983). Estimating the long-term care population and its use of services. Paper presented at the International Social Security Association Sponsored Expert Group Meeting on "Long-Term Care of the Elderly and Disabled", Oslo, June 20-22, 1983.

Ministry of Public Health (1985). *1985 Chinese Health Yearbook*, Beijing: Chinese Health Press.

Nagi, S.Z. (1976). An epidemiology of disability among adults in the United States. *Milbank Memorial Fund Quarterly/Health and Society, 54* , 439-467.

Olson, P. (1987). A model of eldercare in the People's Republic of China. *International Journal of Aging and Human Development, 24* , 279-300.

Population Research Center, Chinese Academy of Social Sciences, 1986. *Chinese population Amanac*, Social Science Press of China, Beijing: Social Science Press of China.

Public Health Bureau of Tianjin (1985). Home health bed is proper way with socialist futures of China. *1985 Chinese Health Yearbook*. Beijing: Chinese Health Press.

Qu, H. (1984). *Status of the Elderly in China*. Research Monograph Series, No. 13. Cairo: Cairo Demographic Center.

Sichuan Committee on Aging, (1986). *The Aged and Society*, Sichuan.

State Statistical Bureau, People's Republic of China (1985a). *Statistical Yearbook of China*, 1985. Hong Kong: Economic Information Agency.

State Statistical Bureau, People's Republic of China (1985b). *Materials on Chinese Social Statistics*. Beijing: Chinese Statistical Press.

State Statistical Bureau, People's Republic of China (1986). *Statistical yearbook of rural China,* 1985. Beijing: Chinese Statistical Press.

Tu, E.J., Liang, J., & Li, S. (1987). Mortality decline and Chinese family structure: Implications for old age support. Paper presented at the Annual Meeting of the Population Association of America, Chicago, April 30-May 3, 1987.

Tu, E.J. & Ting, T.Y. (1988). Consequences of alternative population policies on aging in Chinese Mainland. *Issues and Studies, 24* , 33-48.

Wang, B. & Gu, S. (1986). Unpublished survey file. Hubei, Institute of Population Research, Wuhan University.

World Bank Atlas (1983). *Population, Per Capita Product, and Growth Rates.* Washington, D.C.: World Bank.

Xu, S. & Wu, Z. A survey of the psychological status of the elderly in Beijing. *Newsletter of Psychology*.

Yuan, J. & Associates (1985). *Studies of the Conditions of the Urban Elderly.* Shanghai, Shanghai University.

Yuan, J. (1985). Providing for the elderly in China. Paper presented at the XIIIth International Congress of Gerontology, New York City, July, 1985.

CHAPTER 3

RETIREMENT POLICY, HEALTH AND SOCIAL SERVICES FOR THE ELDERLY IN SHANGHAI

Chang-Hua Wang

Introduction and Purpose

Shanghai is experiencing one of the most rapid growths of an aging population in China. According to the national census conducted in 1982, metropolitan Shanghai, an area which consists of 12 city districts and 10 surrounding counties, has a population of almost thirteen million. Of these, there were 1.3 million persons 60 years old or older, who accounted for about 11.5% of the total population. However, the urban sector of Shanghai, which consists of just the 12 districts, has a population of 7 million, and the percentage for persons 60 years or older is close to 16% in 1982, with life expectancy estimated at 73 years of age.[1]

The purpose of this chapter is to report briefly on retirement policy, social services, health care and educational programs, as well as new developments in rights of the elderly in Shanghai. Only information pertinent to average citizens are presented. Social benefits and retirement policies for those who actively participated in the 1949 Revolution are not covered in this paper, but are available upon request.

RETIREMENT POLICY, HEALTH AND SOCIAL SERVICES FOR THE ELDERLY IN SHANGHAI

General Retirement Policy

According to Section 2 of "The 1958 Temporary Regulations Concerning the Retirement of Employees and Laborers," prepared by the State Council, employees working in enterprises owned by the state, or jointly owned by the state and private groups, all governmental organizations and organizations of the people, are entitled to retirement pensions if one of the following conditions is fulfilled:

1. Any male laborer ("gong-ren", a term designating blue-collar workers) or employee ("zhi-gong", a term denoting white-collar workers) 60 years of age or older, who has worked consecutively for five successive years, or has worked intermittently for a total of more than 20 years, of which 5 were consecutive working years; or any female laborer, 50 years of age and older, or any female employee 55 years and older who has ever worked 15 years, of which 5 were consecutive working years.

2. Those who have to work underground or inside a well, in high places or above ground, or under conditions of unusually high temperature, requiring unusual physical labor, or any activities which may be hazardous to a worker or an employee's health and who, for males, have reached the age of 55 years, or for females, 45 years or older, and who have met the required cumulative working years specified in paragraph (1) above.

3. Male workers and employees 50 years or older and female workers and employees 45 years or older, who have met the required 15 cumulative working years, of which any 5 were consecutive years, and who have been certified by a physician to be physically unable to work due to sickness or injury.

4. Workers and employees who have worked for altogether 25 years, of which 5 were consecutive working years and who, because of illness or injuries, have been certified by a physician to be unable to work.

Retirement Pension and Compensation Guidelines

Workers and employees qualifying under paragraph (1) or (2) above, and who have worked for more than five but less than 10 consecutive years, are entitled to 50% of their last wage scale; those who have worked between 10 and 15 consecutive years are entitled to 60% of their last wage scale, and those who have worked for more than 15 years may receive 70% of the last wage scale (Tables 1 and 2).

Table 1

Eligibility for General Retirement Pensions

Sex	Type of Occupation	Age	Cumulative working years	Consecutive working years	Monthly Pension*
Male	white-collar	60	20	5 - < 10	50% of salary
	blue-collar	60	20	10 - < 15	60% of salary
Female	white-collar	55	15	> 15	70% of salary
	blue-collar	50	15	> 15	70% of salary

*Paid monthly until the employee's or laborer's death.

NOTE: Since 1978, the pensions of persons who have worked for more than 20 consecutive years have been increased to 75%-90%.

Table 2
Eligibility for Retirement Pensions of Persons Working under Special Conditions

Sex	Type of Occupation	Age	Cumulative Working years	Consecutive Working years	Monthly Pension*
Male	white-collar	55	20	5 - < 10	50% of salary
	blue-collar	55	20	10 - < 15	60% of salary
Female	white-collar	45	15	> 15	70% of salary
	blue - collar	40	15	> 15	70% of salary

*Paid monthly until the employee's or laborer's death.

NOTE: Since 1978, the pensions of persons who have worked for more than 20 consecutive years have been increased to 75%-90%.

Workers and employees qualifying under paragraph (3) or (4) above, and who have worked for more than five but less than ten consecutive years, are entitled to 40% of the last wage scale. Likewise, those who have worked between 10 and 15 consecutive years, are entitled to 50% of their last wage scale; and those who have worked more than fifteen years, 60% of their last wage scale (see Table 3). By 1978, the above regulations were amended to allow those who worked more than 20 consecutive years an entitlement of between 75% and 90% of their last wage scale.

Table 3
Eligibility for Retirement Pensions of Feeble and Disabled Persons

Sex	Type of Occupation	Age	Cumulative working years	Consecutive working years	Monthly Pension*
Male	white-collar	50	15	5 - < 15	40% of salary
	blue-collar	50	15	10 - < 15	50% of salary
Female	white-collar	45	15	> 15	60% of salary
	blue-collar	40	15		
Both sexes	white-collar			5 - < 10	40% of salary
			25	10 - < 15	50% of salary
	blue-collar			> 15	60% of salary

*Paid monthly until the employee's or laborer's death.

NOTE: Since 1978, the pensions of persons who have worked for more than 20 consecutive years have been increased to 70%-90%.

Older persons who have never participated in the labor force are not entitled to receive retirement pensions. If any of their adult children are employed, they may apply to have 50% of their medical expenses paid by any one of their children's work units.

Elderly without any living children can apply for welfare assistance from the government. Rural persons do not have retirement pensions. Childless widows and widowers are protected by a government entitlement to clothing, food, shelter, medical and burial expenses. Workers of rural village-, township-, county-governmental units and state enterprises are entitled to retirement pensions. Before 1956, mainland China did not have private enterprises. At present, employees and owners of private enterprises (called "geti hu") are not entitled to retirement benefits. Beginning in 1983, intellectuals and professorial personnel in higher education, whose rank is associate professor ("Fu jiaoshou"), associate research fellow ("Fu yanjiu yuan"), or the equivalent, can extend their active employment to 65 or 70 years of age. Upon retirement, they are entitled to between 95 and 100 percent of their last wage scale.

Social Services for the Elderly in Shanghai

1. Formal Care for the Elderly

A. Social Welfare Homes and Homes for the Aged

By the end of 1987, there were four homes for the aged operated by the city government of Shanghai, housing a total of 1,327 elderly persons. District- ("qu") and sub-district ("hsien") operated homes for the aged totalled 11, housing altogether 347 elderly. Street-committee- ("jiedao") operated homes totalled 16, housing a total of 1,600 elderly.

Homes for the aged located within the city boundaries of Shanghai provide RMB $60/month directly to each resident for living expenses, the amount being paid out of the municipal budget supplemented by collective work units. Homes for the aged in the suburban areas totalled 220 facilities, with a count of 2,899 residents. The per capita cost of board and lodging the elderly is RMB $859/year or RMB $71.58/month, the amount being paid directly to the management of these homes out of the budget of rural village and township governments. Able-bodied elderly may work on a voluntary basis in various aspects of recreational cultural, educational activities available in these retirement homes.[2]

B. Five Protections for the Elderly

In rural areas, elderly individuals without children or relatives to care for them, and who are not residents of homes for the aged, are taken care of by the rural collective organizations in the villages where they live. They enjoy the five protections called "wu-bao," which include the guarantees of clothing, food, shelter, health care, and burial. The 1987 statistics showed that in the immediate suburban and rural communities surrounding Shanghai, there were 362,000 elderly persons enrolled in such programs. The cost per capita of taking care of these elderly is RMB $12 per month, paid for by the three levels of government in the rural areas -- the sub-county ("xiang"), the village ("chun"), and the brigade ("duei").[3]

C. Old Age Insurance

An old age insurance system is being tried out presently in Shanghai. To enroll in this program, an elderly person or his/her work unit contacts an insurance company and contributes on a fixed monthly basis to the insurance premium. When the insured reaches the retirement age, the policy pays monthly benefits.[4]

D. General Health Care for the Elderly

Hospitals and clinics operated by various levels of the City's administrative units have outpatient care departments exclusively for senior citizens. The elderly have the privilege of being served first upon registration and admission, and of having a specialty hospital with a 50-bed capacity devoted exclusively to geriatric medicine.

2. Informal Care

A. Informal Protection for the Childless

Persons admitted to social welfare homes and homes for the aged represent only about 14.6% of the childless and kinless ("gu-lao") elderly; that is, persons without kinship support, particularly children. Under these circumstances, a new concept has emerged called the "bao-hu zu" or Elderly Protection Group, sometimes translated as Elderly Nursing Group. Participation in the bao-hu zu is on a voluntary basis. The usual procedure is for representatives of the street committees (jiedao") and neighborhood groups ("jumin xiaozu") to organize volunteers in small groups ("jumin xiaozu") of 3 to 5 persons for the purpose of overseeing the daily activities of senior citizens in that neighborhood. Within the city of Shanghai, there are presently more than 4,200 such bao-hu zu's or Elderly Protection Units (EPU), serving more than 8,000 older individuals. The volunteers involved in providing such services numbered more than 22,000 persons. The bao-hu zu's functions include the following types of services: household management, grocery and general shopping household repairs, house cleaning and laundry, haircut, health services, bathing and birthday celebration, among others.[5]

B. Care for Elderly Parents by Adult Children

At present, most care for the elderly in Shanghai, as well as in China, is provided by their own children. The Marriage Laws, promulgated as the first legislative action after the establishment of the Socialist regime on the mainland in 1949, specified that "... it is the responsibility of children to care for their aged parents. When there are no adult children, the aged should be cared for by their surviving grandchildren from the paternal or maternal lineage. Likewise, these grandchildren have the responsibility to care for their paternal and maternal grandparents who are, otherwise, without relatives to care for them."

3. Gerontological Societies

A. Geriatric committees or societies for older persons have been formed at the city, district (gu), and county (hsien) levels to study the problems and service needs of the elderly, and to disseminate such information to the appropriate governmental agencies.

B. Geriatric medicine associations for the elderly have also been formed at the city, district, and county levels to provide the different specialty-based associations within the Zhong-Hua YiXue Hui (Chinese Medical Association) with relevant research and information on the patterns of disease in old age, health care for the elderly, health prevention and health care policies. These data are forwarded to the appropriate offices of the Bureau of Health.

C. Gerontological societies, such as the Society for Geriatric Care, have been established in Shanghai as a lay organization with a more "academic" or intellectual interest. Their functions are similar to those of the previous two types of organizations.

D. Administration support committees for city and for retired laborers and employees have been established in Shanghai to enable professionals to provide services to retired laborers and employees.

E. Geriatric sports and physical fitness associations have also been organized by the municipal district and the sub-district (hsien) governments. About 25% to 30% of all elderly persons participate in physical fitness clubs throughout metropolitan Shanghai. Membership totalled 24,600, with 53% being males and 47% females. These clubs have programs of Taichi, physical exercises, Ping-Pong, jogging, and disco dancing for the elderly.[6] On June 10, 1988, some 4,000 elderly athletes participated in 15 categories of sports competition during the Second Annual Geriatric Sports event in Shanghai.[7]

F. The Shanghai Association for Retired High-Level Professionals emerged as a voluntary organization in May of this year. Its functions are: (1) to encourage public acceptance of the reforms on strategic developments being promulgated by the various offices of the government by means of such activities as discussions and examinations of the issues, formulations or suggesting revisions of policies, documentation of materials, and dissemination of information. (2) organize literary activities such as the establishment of groups for writers, special editors, translators, and publishers to undertake specific projects, and (3) the training of professionals. The membership of this organization exceeds 1,000 persons.

4. Social Activity Groups

Social activity groups are available in the city of Shanghai for the elderly who are in good health, able to work physically, have an education, a special technical or language skill, or a professional specialty. Some of these elderly have been invited to serve as consultants either in their original place of work prior to retirement or in another work unit.

Prior to the 1980s, the elderly had been active in various types of voluntary work, such as serving as volunteer traffic cops or park overseers. After 1980, this work was no longer performed without pay. Rather, the elderly were paid by the number of days worked at the rate of 1-2 yuans a day. Since the institution of the free market system, some of the elderly in Shanghai have set up small businesses.

For the elderly living in rural areas or homes managed by the street committees, the following types of social activities are generally available: afternoon tea and concert programs, chess sessions, and poker games.

Educational Services for Senior Citizens

Educational institutions serving senior citizens are found on three different levels of government: city, district or county, and neighborhood group. The city municipal government has three colleges with a total enrollment of 3,556 students aged 60 years or older. There are 50 other educational institutions throughout Shanghai's various districts and sub-districts which provide education comparable to the secondary level of middle schools, serving a total of 1,800 elderly students. In addition, there are numerous primary schools provided by street committees and neighborhood groups throughout the city.

The college-level curricula include literature, calligraphy, brush painting, photography, music, drama, gardening, home economics, cooking, health care, and physical education. The last two are required courses for all senior citizens. There are now plans to offer courses for senior citizens through correspondence schools and "television colleges".[8] The latter are colleges in which the courses are offered through special television programs, China's way of quickly promoting mass education.

Elderly Rights

In 1987, the Jia-Ding Gerontological Society's survey reported that between January and July of that year, a total of 22 elderly persons committed suicide because their rights were infringed upon or violated. The country has not yet formulated any laws to protect the rights of the elderly. On June 1, 1988, Shanghai City's Ninth People's Congress discussed a document drafted by the city government, entitled "The Legal Protection of the Elderly's Rights in Shanghai." The document requests that Chong-Yang Festival (September 9th of the lunar calendar of each year) be designated as Shanghai's Respect-for-the Elderly Day. At the same time, the document recommends the use of education primarily, and rehabilitative sanctions only secondarily, under due process of law, to protect the freedom of the elderly to get married, to be taken care of, and other rights to which they are entitled by law. After several reviews and discussions, the recommendations have been approved and will be implemented in Shanghai, effective October 15, 1988.[9]

Endnotes

1. Wei-Liang Huang, *Laonianxue Zazhi* (translates into English as "Journal of Gerontology") volume 4, no.2 (1986): 46.

2. Annual Meeting of the *Shanghai Laonianxue Hui* (translates into English as the Shanghai Gerontological Society), 1987.

3. Annual Meeting of the *Shanghai Laonianxue Hui* (translates into English as the Shanghai Gerontological Society), 1987.

4. Bing Wang, *Laonianxue Zazhi* (translates into English as "Journal of Gerontology") volume 6, no. 3 (1986): 8.

5. Annual Meeting of the *Shanghai Laonianxue Hui* (translates into English as the Shanghai Gerontological Society), 1987.

6. Zicai Du. *Laonianxue Zazhi* (translates into English as "Journal of Gerontology") volume 8, no. 2 (1988): 65.

7. *Jie-Fang Ribao* (Liberation Daily), June 12, 1988.

8. Zicai Du, *Laonianxue Zazhi* (translates into English as "Journal of Gerontology") volume 8, no. 2 (1988): 65.

9. *Jie-Fang Ribao* (Liberation Daily), June 3, 1988.

CHAPTER 4

INFORMAL SOCIAL SUPPORT SYSTEMS IN CHINA

William T. Liu

Purpose

The purpose of this chapter is to describe the informal social support system of the elderly in China, using data collected from a probability sample survey conducted in Shanghai. Gerontological research on the social and health needs of older people in China has been based largely on verbal descriptions of needs through analyses of official policies and interviews with informants (Davis-Friedmann, 1983, 1985; Liu, 1982; Yuan, 1981; Zeng, 1983). Few, if any, systematic sample surveys have yet appeared in print, although several such studies have been conducted in Tienjin (Gui, et al., 1987; Li, et al., 1987; Pang, et al., 1987). This chapter is based on 5,050 interviews of older persons, aged 55 and over, residing in one of the ten administrative districts in metropolitan Shanghai. The random probability sample was drawn specifically to oversample the older age groups (65-74, and 75 and over) in order to produce nearly equal numbers of elderly in three age cohorts: 55-64, 65-74, and 75 years and older. The sample design has been described elsewhere (Levy, 1987, unpublished) and will not be described here.

The Family as an Informal Social Support System

To begin a study of the informal social support system in China, it is impossible not to touch upon the role of the family, which in a sense differs from our normal usage of the word in the West. The generic term "chia," or the family, includes anyone who is a member of the "domestic-group". There have been some drastic decades of repeated political campaigns. As a collective movement, there is a certain fundamental incompatibility between collective identification, on the one hand, and family solidarity on the other. Kinship is based on the maintenance of intergenerational ties and a certain basic continuity of transmitted tradition. Between the non-selective and non-ideological kinship obligations and a universalistic criterion of ideologically based comradeship, boundaries of the domestic group shift on both the national and the individual levels as social change continues to take place in mainland China.

The Party and state leadership has been ambivalent about the role of the family. On one hand, family identity promotes the maintenance of a particularistic relationship which could run counter to the interest of the state and the revolutionary goals. On the other hand, many issues of welfare, housing, old age pensions, health care, and social problems, which normally would require huge state investment, have been relegated to the family. To the Party leaders, old age and child care, for example, could only be domestic problems unless one does not have close kin. The assignment of familial obligations can be taken as strengthening the mutual identity of family members and, at the same time, reaffirming a culturally accepted perspective that such problems really did not exist for the state.

There are additional historical and demographic reasons for the absence of problems of the elderly until the beginning of the eighties. A relatively small proportion of the huge population aged 65 and over was in fact the result of a high fertility pattern, encouraged by Mao Zedong at the beginning of the Socialist regime. Furthermore, China has had a national pension program since the beginning of 1951 (Davis-Friedmann, 1983; 1985). Even though eligibility criteria for state retirement pensions had excluded about 80% of the labor force, the vast majority of the people resided in rural communities where the aged, as compared with their urban counterparts, do not experience discontinuity of either employment or cash income. Finally, besides being supported by their adult children, older people often depend on marginal employment in the neighborhood. Thus, despite the limited access to old age pensions, few elderly become destitute. China is probably one of the few countries in which nursing homes and elderly residential facilities are scarce in relation to the number of people age 65 and over.

In short, informal support systems for the elderly must be viewed within the larger context of familial and kinship structure, social networks, demographic patterns, housing and welfare patterns of the society.

Government Policy on Retirement

Government policies on retirement are closely associated with, and explained by, the modernization policy which takes precedence over other issues germane to the elderly. These modernization programs, more directly related to economic reforms, have important and profound implications for the retirement of older workers, the pension incentive system to counter lower bureaucratic resistance, and continuation of a favorable wage system to keep pace with the life cycle of individual workers. Modernization policy should be viewed as the context for the assessment of the informal support system for the elderly.

A. Economic Reforms. The dramatic change of population policy announced in the seventies from a pronatal to a one-child per-couple policy will have a direct impact on the population structure for decades to come. Though exceptions were allowed for ethnic minority populations and for remote rural areas, the Chinese government has generally been rather uniform in enforcing the one child policy.

Along with the explicit population growth-control policy is state investment in housing construction in older cities, which had been badly needed for years. The abolition of the rural commune, the opening of free markets for goods and services, the institutionalization of a work incentive policy, and the implementation of mixed, centrally controlled and market economies have resulted in a remarkable short-term economic growth throughout the system. These changes have produced a sharp rise in consumer prices and have raised the standard of living in some urban and rural sectors.

Modernization of the economy inevitably calls for the retirement of older, ideologically promoted, cadres who were in key economic and political positions at the end of the Gang of Four era. To this end, the Party leaders announced in the early eighties the abolishment of life tenure for old cadres, and the promotion of younger cadres to leading posts (*Beijing Review*, 1982, 25:3). In spite of increased pension incentives for the newly retired cadres, there remains a large segment of the older population without the protection of a pension system.

B. Retirement Pensions. Government policy on retirement, pensions, and other benefits for the elderly have been periodically reported in official media publications. A summary of the Chinese policy on pensions is available in both Chinese and English language publications (Ascher, 1976; *Beijing Review*, 1982; Davis-Friedmann, 1985; Liu, 1982; Parish & Whyte, 1978). A thorough treatment of the issue by Davis-Friedmann reported that a pension remains a privilege for a minority of state workers, and not as a universal entitlement program. Thus, in spite of the increasing number of older people, in general, the number of pensioners has not kept pace. (Davis-Friedmann, 1985:296).

Davis-Friedmann noted that the period before 1978 had no compulsory retirement policy for state employees. In fact, during several political struggle periods, retirement by those healthy workers was considered anti-socialist. The 1978 revision of the Labor Insurance Regulations specified that ages 60 and 50 were retirement ages for male and female workers respectively, though enforcement might not have been universal (Davis-Friedmann, 1983). Retirement became a more prominent issue when, in 1982, senior government officials were asked to retire (*Beijing Review*, 1983). The age that was set for officials at the ministerial level was 65, and 60 for those at the subcabinet level. To compensate for the loss of bureaucratic privileges and political power, the Party increased significantly the retirement pensions to those who served the Party before 1949.

Here again, such mandatory retirement was not implemented on an across-the-board basis. Many of the highly skilled state employees were asked to stay. The juvenescence of the huge bureaucracy had initially met formidable political opposition even when it was adopted as a part of the country's modernization programs. In a socialist totalitarian state, such resistance has been described in part as a form of bureaucratic politics (Olson, 1987; Orloff & Skocpol, 1984) in that the significant interest groups are those persons and units within the bureaus of government rather than those out in the public arena (Olson, 1987). The increased pension and other benefits (better and larger housing quarters, for example) provided incentives for aged bureaucrats to lower their collective resistance.

C. Post-Retirement Employment. A substantial proportion of retirees continue to work on marginal jobs or on jobs not connected with their previous employment units. With their pensions, the supplemental income may add to a total income for the retired person much higher than their income prior to the retirement. Thus, it is not unusual to find the highest income years are those within five years after retirement, for men and women between 55 and 65.

Our survey data in Shanghai, based on more than 5,000 interviews with persons 55 years or older, showed that a little less than ten percent of current retirees are working on a full-time basis and another 1.2% on a part-time basis. Only 1.6% of the respondents said that they could not find jobs. On the other hand, about 88% said that they did not wish to continue work after retirement.

The unwillingness to continue working is probably best explained in economic terms. The income structure favors senior workers and older age cadres, especially those who receive retirement pensions. Taken as a whole, our data show that the reported aggregate income of persons of pre-retirement status is significantly lower than that reported by the retired elderly. One-third of those persons 55 years or older who are currently working (therefore, not retired) reported having an income of RMB$45/month or less. About one-half said their income was RMB$67/month or less. Only 20% of the total respondents reported an income greater than $103. These figures are in sharp contrast to those reported by the retired segment of the population who are of the same age group (i.e., 55 years or older). One-third of the retirees reported having an income of RBM$76/month or less (as compared to RBM$45.00 for the not-retired population). One-half of the retirees have income of RMB$93.00/month (compared to only RMB$67.00 for the not-retired elderly), and 20% of the retired have RMB$120.00/month and over (compared to only RMB$103 for the not-retired). The mean income for the currently-working elderly was $69.20 at the time of the survey, and the median income was $67.00. For the retired elderly, the mean income was $99.80 and the median income was $93.00. Given the relatively stable individual income system in China without substantial increments in recent years, it is not necessary to separate cohorts of retirees by periods.

The important factor, however, is the way family members pool their income in one way or another. A housing shortage and cultural factors have kept retirees with their married adult children in the same household, a point on which we shall provide more detailed data below. The preliminary analyses of these figures indicate that retirees are economically, or at least psychologically, more secure than the pre-retired elderly. In addition, most of the urban elderly in China share their resources and hand over at least a part of their income to their elderly parents. Thus, the government, through its low-wage structure for the currently-working population and a generous retirement-pension policy, has in effect provided both economic security and social prestige for the elderly population. In general, older people have a higher income and a wider network of connections than younger people. Such a network of connections, known as quanxi, is in fact an asset of potential personal influence.

Informal Support Systems for the Elderly in Shanghai

The formal support system for the elderly in China appears to be rather weak when compared with societies in the West because of the philosophical values attached in traditional culture to filial piety, which defines the child's duty to care for the aged. The pension system favors those who contributed to the earlier stages of the Revolution and to the Party and the State. Retirement programs are implemented through bureaucratic political processes at present and, probably, will be universally administered in the future when the current cohort of older cadres retires and a new generation of young-old leave their posts to allow younger leadership to take charge of the country's ambitious modernization programs.

These changes notwithstanding, it remains true that the family is the chief care unit for the elderly in spite of the fact that the Chinese family structure has shifted dramatically since the Revolution of 1949. State work assignment, mass internal migration during the mid-and late 50's, various political movements, and the Great Cultural Revolution all have contributed to the changes of the domestic group. Crises and utilitarian designs to meet the requirements of the Party for desired place of residence and work, and the one child policy, have added to the strengthening of the family as a domestic group, but the demands of work and change of residence which segmented the kin group have made it impossible to describe the Chinese family system in static terms.

What remains true, however, is the fact that generation extension and cohesion are still kept as an ideal form of familial relations. Due primarily to the improvement of public health and the standard of living for the poorer and rural populations since 1949, there has been a noticeable extension of persons surviving into old age. There has also been a concomitant shrinkage within generational cohorts because of decreasing fertility rates. The latter trend is substantiated by the fact that household size in the early 1970s had an average of about 3 children, compared to the one child per couple widely practiced in the eighties. The extension of generations is supported by the fact that close to eight percent of those selected for interview (age 55 and over) also have living parents over the age of 70. Eleven percent of those who reported having both parents still alive at the time of interview were people over 75 years of age. Fifty percent of those interviewed have four or more living children, and about twenty percent have four living children, 17% had three living children and 15% had five living children. Thus, it is possible to describe a statistically available pool of informal support system surrounding the elderly at the end of the eighties in China. Future studies will periodically monitor the changes in the informal relationships of the elderly.

A. Nuclear Family As an Informal Support System. Having a spouse is considered the most important source of emotional and social support (Shanas, 1979). In the Shanghai data, 62% of the elderly are married and living with their spouse, whereas 31% are widowed. These figures are comparable with the U.S. data in the 1980s, although in both countries the percentage of males over the age of 65 is about twice as high as for females of the same age cohort (U.S. Bureau of the Census, 1982).

Siblings provide support as well. In the United States, more than seventy percent of persons over the age of 70 have living siblings (Shanas, 1979). In the Shanghai survey, 68% reported having living siblings. These two figures are not comparable, since the Shanghai sample consisted of people 55 years of age and over. Figures for those over 75 and over 65 are not available at this time.

Co-residence with adult children is infrequent in the United States. However, it is common that adult children live close-by. In the same study, Shanas (1979) reported that 75% of her respondents have children living within 30 minutes by car.

The Shanghai data show that more than 73% of the elderly actually live with their children. In addition, 63.7% of the total sample also reported that there are other relatives sharing residence with them. Only 6% of the more than five thousand cases reported living alone. The affective component between generations appears on the average to be strong, though measures of affectivity are difficult to define. In general, 84.6% said that they see their children on a daily basis, which is not surprising in view of the fact that 73% actually live with their children. In addition, another 8% see their children on a weekly basis, giving a total of more than 92% of the respondents who have ready access to their children. Since telephone communication within China is both expensive and inconvenient, information on phone and mail contacts with adult children corresponded closely with face-to-face contacts. More than 92% have such contacts with their children.

Interaction with children often extends beyond just providing companionship for each other. For the majority, there is an exchange of mutual help. The most frequently mentioned help has to do with household chores. Children render more health care to their parents whereas the latter provide material things for their children. Living in the same household, however, makes such specific functional contributions between parents and their adult children somewhat ambiguous. There have been studies, for example in the United States, which show that although the elderly report high levels of affection in their relationships with children, they tend to minimize the amount of assistance or exchange of services. The Shanghai data pose similar questions as to how such data can be interpreted. Singling out services and assistance between parents and others may not be applicable in the Chinese family, since it is expected that people living in the same household share common tasks. In short, the overwhelming majority of our respondents reported strong and cohesive nuclear family ties.

B. Contacts with Kin-relatives. Contacts with more distant kin, including grandchildren, are equally intensive. More than fifty percent said that they have their grandchildren live in and close to 68% said that they helped with the caring of their grandchildren.

Living with other relatives, such as in-laws, siblings, and cousins, ranged from more than 33% for daughters-in-law, to less than one percent for siblings. Living with other female relatives was reported by more than 6% of the respondents, compared with only 2.4% who reported having male distant relatives. Our tentative conclusion is that the inter-generational cohesion exceeded cohesion with other distant relatives. Siblings are among relatives with whom there are the least contacts, judging from the patterns of co-residence.

On the other hand, close to 15% of the respondents said that they have get-togethers with their kin-relatives at least once a month. Another 60% said that they have kin gatherings at least once a year, probably during the Chinese New Year's holidays.

The type of relations makes a great deal of difference with respect to emotional intimacy and trust. Spouses are mentioned by one-half of the respondents as their confidants; another 20% named one or more of their children. Sixteen percent, however, named their co-workers as their confidants; about 6% are siblings. Only about 3.5% named their neighbors as their close confidants to whom self-disclosure was reported. Similarly, non-specific confidants, or "friends" constituted only 5% of the total responses. It raises serious conceptual questions about the concept of "friend" and "friendship" in Socialist China (cf. Liu, 1986, for a discussion).

Conclusion

In an earlier paper, based on a separate sample survey on stress and psychological illness conducted in 1983, I argued that in spite of the revolutionary commitment, the Communist Party leaders did not minimize the importance of the "family" in the new society. Social welfare policies, particularly those pertaining to the care of the elderly, made paramount a closer interdependency among members of the family, which goes beyond the nuclear family. Inter-generational cohesion takes priority over all other types of relations. Like other countries in the West, spousal and adult-children supports constituted the core of the informal support system.

The continuous political movements, an attempt to flush out ideologically deviant elements in the Socialist society, have failed to establish comradeship based on friendship. Informal support for life crises may have to depend on neighbors and friends, such as the organizational monitoring system established in urban China. Emotional intimacy, however, is found mainly among closest relatives, within the nuclear family, and is found only among other relatives as a distant second.

Finally, because of the organizational imperative within the huge bureaucracy in China, one's work unit has become a total institution in Goffman's sense. Supervisory cadres serve not only as the superior at the workplace. They also serve in the role of one's "confessor", teacher, and one who can really help in time of needs and crises. It is therefore not surprising that more than 16% named co-workers as their intimate confidants.

References

Ascher, I., *China's Social Policy.* London: Anglo-Chinese Education Institute.

Davis-Friedmann D., (1985). "Chinese retirement: Policy and practice. *In Current Perspectives on Aging and the Life Cycle*, vol. 1, Pp. 295-313, JAI Press.

Davis-Friedmann, D., (1983). *Long Lives.* Cambridge: MA.: 1983. Harvard University Press.

Gui, S., et al., (1987). "Work and Family in Tianjin." Paper read at the Annual Meeting of the American Sociological Association, Chicago.

Levy, P., (1987). "Statistical Sample Design of the Shanghai Elderly Survey by P/AAMHRC." Unpublished working paper. Chicago: Pacific Asian American Mental Health Research Center.

Liu, L., (1982). Mandatory retirement and other reforms pose new challenges for China's government. *Aging and Work, 5* , 119-130 .

Liu, T., (1986). "Friendship and Kinship in Contemporary China" Paper Given at the East Asian Research Center Symposium.

Olson, P., (1987). A model of eldercare in the People's Republic of China. *International Aging and Human Development*, *24* (4), 279-300.

Pang, J., et al., (1987). "Work and Family in Tianjin" Paper read at the Annual Meeting of the American Sociological Association, Chicago.

Parish, W., & Whyte, M., (1978). *Village and family in contemporary China*. Chicago: University of Chicago Press.

Shanas, E. (1979a) The family as a social support system in old age. *The Gerontologist, 19* , 169.

(1979b). Social myth as hypothesis: The case of the family relations of old people. *The Gerontologist, 19* .

Shanas, E., & Maddox, G., (1976). Aging, health and the organization of health resources", Binstock, R., & Shanas E., (eds.) *Handbook of Aging and the Social Sciences*. (Pp. 592-618). New York: Van Nostrand Reinhold.

Shanas E., Townsend, P., Wedderburn, D., Friis, H., & Milhoj, P., (1968).*Old people in three industrial societies*, New York: Atherton Press.

Yuan, J., "Living Conditions of Elderly Retirees in Shanghai". Paper presented at Conference on Retirement in Cross-Cultural Perspective. Bellagio, Italy.

Zeng, S., (1983). China's Senior Citizens. *China Reconstructs 31,* 5-8.

CHAPTER 5

COGNITIVE IMPAIRMENT AMONG THE ELDERLY IN SHANGHAI, CHINA

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Purpose

The purpose of this paper is to present data on the prevalence of cognitive impairment, as measured by the Mini-Mental State Examination (MMSE), among more than 5,000 non-institutionalized persons 55 years or older currently living in Shanghai--the largest city in China.[1] This work, conducted in 1987, represents the first phase of a large-scale psychiatric epidemiologic research program of Alzheimer's Disease and Dementia in Shanghai. The program is a collaborative project of three institutions: the Shanghai Institute of Mental Health (SIMH) in China, the Alzheimer's Disease Research Center (ADRC) at the University of California, San Diego, and the Pacific/Asian American Mental Health Research Center (P/AAMHRC) at the University of Illinois in Chicago.

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COGNITIVE IMPAIRMENT AMONG THE ELDERLY IN SHANGHAI, CHINA

Background

In the United States, community surveys of psychiatric disorders in general have had a long history, first dating back to the use of treatment data for case identification in 1855 (Jarvis, 1971), followed by the key-informant method in Lemkau et al.'s study of the Eastern Health District of Baltimore in 1933 and 1936 (Lemkau et al.,1941, 1942a, 1942b, 1942c, 1943), Roth and Luton's survey in Williamson County, Tennessee in 1935, to the recently completed Epidemiologic Catchment Area studies in five sites using fully-structured instruments and highly standardized procedures (Burnam et al., 1987; Myers et al., 1984; Robins et al., 1984).

In contrast, the first psychiatric epidemiologic survey in the People's Republic of China did not take place until 1958. Between 1958 and 1981, a total of 61 psychiatric epidemiologic investigations have been conducted in at least 20 locations throughout China. Of these studies, 42 relied upon the key-informant method for case identification (Wang, 1983). By 1981, only six of the 61 psychiatric epidemiologic investigations had been reported in journals accessible outside China (Lin & Kleinman, 1981). None of the studies focused specifically on the elderly population, although data on types of disorders were sometimes presented by age. However, because the elderly represent a small proportion of the total population sampled in these general population studies, the resulting estimates of rates of mental disorders for the aged population have low reliabilities.

Between 1981 and 1986, a few large-scale psychiatric epidemiologic studies were conducted in collaboration with researchers from Europe and the United States. The first was a WHO-Collaborative Study with the Department of Health in 12 sites using an instrument developed in England, the Present State Examination (PSE) (cf. the *Chinese Journal of Neurology and Psychiatry, 19* n., 1986). The second study, conducted in Shanghai by the (SIMH) in collaboration with the P/AAMHRC at the University of Illinois, used an instrument developed in the United States, the DIS (Diagnostic Interview Schedule) Version III (Liu et al., 1984; Wang et al., 1988; Yu et al., 1988).

Although neither survey sampled persons 65 years or older, they were developments in the history of psychiatric epidemiology in China because they marked the beginning of Chinese psychiatrists' experience with the use of semi-structured (in the case of the PSE) and fully-structured (in the case of the DIS) diagnostic instruments in community-based research on mental disorders.

For surveys of senile disorders, a review of the journals in the People's Republic of China suggests that the first published study, using the key-informant method, appeared in 1981 (Kuang et al., 1981). That study was quickly followed in 1983-84 by what is probably the first large-scale survey of mental disorders among the elderly in China using the PSE as the instrument for gathering diagnostic data (Chen et al., 1987). The latter, conducted in the West-City District of Beijing, showed strikingly low rates of Alzheimer's Type Dementia (0.38 percent of 8,740 elderly surveyed who were 60 years old or older), Multi-infarct Dementia (0.43 percent), and other Organic Brain Syndrome (0.46 percent). The absence of detailed information on the precise criteria adopted by the interviewers to determine caseness makes it difficult to evaluate the reported rates. As is widely known, the PSE, being a semi-structured rather than a fully-structured diagnostic instrument (see Wing et al., 1977; Wing, 1983; Wing, 1986), allows the interviewers freedom to decide what to probe. In community-based mass screening procedures, that freedom is likely to compromise the prevalence rates of dementia.

Besides the Beijing study, a review of the published literature in both Chinese and English language sources shows that no other studies of dementia in China have been reported at this writing. The Shanghai Study of Alzheimer's Disease and Dementia, whose findings are reported in this paper, is the first study in China to extract diagnostic data on Cognitive Impairment from a fully-structured screening instrument developed in the U.S. -- the Mini Mental State Examination (MMSE). The screening process is being followed by intensive clinical evaluations of positive cases to ascertain the diagnoses of dementia. A team of Chinese-speaking psychiatrists, trained by neurologists from the Alzheimer's Disease Research Center in San Diego, has been conducting the clinical evaluations in Shanghai.

Methods

A. The Shanghai Study of Dementia

The Shanghai Study of Dementia was launched in 1987 after three years of preparatory work which was initiated by the visit to China of a U.S. Delegation on Aging and Mental Illness under the leadership of William T. Liu.[2] Between 1985 and 1986, members of the research team were engaged in the construction of research instruments, modifications of culture-inappropriate items, translation and pretests in Chicago (with a sample of 159 elderly) and in Shanghai (with a sample of 150), as well as training of interviewers. The community survey consists of a probability sample of persons 55 years or older residing within the Jing-An District, one of 12 districts which comprise the City of Shanghai. It had a population of 497,657 at the end of 1985.

B. Household Selection

Like other districts in Shanghai and elsewhere in China, Jing-An (meaning Quiet and Peaceful in Chinese), is organized into Street Committees (10 within the District), Neighborhood Committees (10-26 per street committee), and Neighborhood Groups (10-30 per Neighborhood Committee).[3] The most recent population statistics supplied by officials of Jing-An District indicated that there are approximately 56,000 persons 55-64 years of age; 35,000 persons 65-74 years; and 16,000 persons 75 years or older. Information on age-specific mortality rates was not provided. Because of the availability of household registry data, it was strongly recommended by the Community Advisory Committee of this project that neighborhood groups should be the ultimate sampling clusters. Likewise, it was recommended that response rates and cooperation would be enhanced if all elderly within a sampled neighborhood group were considered eligible for interviews. Since all eligible elderly within a sampled neighborhood group would be interviewed, a simple random sample of neighborhood groups would result in an unequal number of individuals within the three targeted age groups. Therefore, a sampling design was devised based on the knowledge that the population sizes for these three age groups are not too far from being in a 3:2:1 ratio (i.e., a little more than three times as many 55-64 year olds as 75+ year olds, and about twice as many 65-74 year olds as the 75+ year olds).

The community sample was drawn in two stages: first, the selection of a random sample of neighborhood groups and, second, the selection of the individuals for interviews. A printout was prepared listing street committees within the district and neighborhood committees within streets prepared especially for this study. These forms were processed in the field office to identify the respondents to be targeted for interviews. Furthermore, several echelons of community leaders from the Street Committees down to the Neighborhood Groups were personally contacted and asked to assist in helping the research team and the interviewers make contacts with community residents.

C. Interviewing

Interviewing was conducted from the beginning of January, 1987, through the end of May in the same year. The interviewers were recruited from the pool of psychiatrists and nurse practitioners working at the Shanghai Institute of Mental Health, the Shanghai Psychiatric Hospital, and their satellite health stations. The interviewer training session lasted 10 days, with Chinese-speaking U.S. members of the collaborative research team serving as training faculty. Several rounds of mock interviews were conducted to teach the interviewers how to obtain accurate mini-mental status examination scores and handle potentially difficult problems tactfully. After the interviewers became familiar with the flow of the instrument and the handling of difficult interview situations, live interviews were conducted for training purposes with the following categories of respondents: (a) co-workers who are native speakers but uninformed abut the purpose of the research instrument; (b) co-workers' elderly relatives who are not familiar with social or psychiatric interviews and who can give lay criticisms of the instrument; (c) patients from the Shanghai Psychiatric Hospital who were not demented; and (d) patients from the hospital who showed signs and symptoms of dementia. Training video tapes were used and the scoring rules were discussed and agreed upon. Each interviewer trainee was observed on two live interviews to ensure high inter-rater reliability.

D. Response Rate

By means of the sampling procedures described above, a total of 6,634 eligible respondents was identified for the survey. Of these, interviews were completed on 5,271 persons (79.5 percent completion rate). The reasons for not completing the remaining 1,363 targeted persons are shown below:

R was travelling/staying with children or relatives outside of Jing-An	1,202
R had moved outside of Jing-An and household registry was not yet updated	85
R passed away and household registry not yet updated	34
R had serious physical illness and no proxy available	18
R explicitly refused to be interview	24

Of the 5,271 persons who completed interviews, the Chinese Mini-Mental State Examination could be administered to only 5,055 persons (95.9 percent of the completed interviews). For the 216 persons who could not be administered the CMMSE, other questions in the elderly survey instrument were successfully completed with the assistance of a caretaker. These interviews are called proxy interviews. Direct testing of the respondent by means of the CMMSE could not be performed on the 216 respondents because of the following reasons:

R is extremely deaf	159
R is blind	17
R is paralyzed and has difficulty talking	17
R has serious physical illness	3
R has psychosis	7
R is clinically demented	4
Others	9

The four cases of clinically demented respondents were in such a state that administration of the CMMSE was not possible. For this reason, the reader is cautioned that the estimates of cognitive impairment in the paper do not reject the presence of these four cases of clinically severe dementia.

E. Data Quality Assurance

Completed interview booklets were submitted to teams of supervisors. The first team monitored the day-to-day activities of the interviewers and provided immediate feedback to interviewers by means of manual inspection of the protocols to detect missed questions or erroneous skipping of questions, as well as ambiguous responses. The second team of supervisors provided computer-automated controls on the quality of interviewing by applying a PC data entry and validation program brought to Shanghai and set up specifically for this study. The entire dataset, stored on diskettes, was brought to the Pacific/Asian American Mental Health Research Center for consistency checks and data processing.

F. Sample Weights

The sample design discussed above was a single-stage cluster sample[4] and permitted persons 55-64 years of age to be interviewed in one-third of the sample neighborhood groups; persons 65-74 years to be interviewed in two-thirds; and persons 75 years and older in all of the sample neighborhood groups. Since approximately 1 in 9 neighborhood groups was sampled, the sampling fractions were, therefore, approximately 1/27 for persons 55-64 years of age; 2/27 for persons 65-74 years; and 3/27 for persons 75 years and older.

Estimation methods used in this study were those appropriate for single-stage cluster sampling with sample weights for each individual being the inverse of the sampling fractions discussed above. Since the sample weights were the same for each individual within the same age group, age-group-specific estimates did not require the use of sample weights.

G. Mini-Mental Status Exam (MMSE)

A measure of cognitive impairment used in the survey is the Mini-Mental State Examination (MMSE). It is a simplified form of the cognitive mental status examination which assesses, among other things, a person's orientation to time and place, instantaneous recall, short-term memory, and ability to do reverse spelling. A total score, which ranges from 0 to 30, is produced for each respondent by summing the points assigned to each successfully completed task. In the words of Folstein, Folstein, and McHugh (1975:189) who developed the instrument, "It is mini because it concentrates only on the cognitive aspects of mental functions, and excludes questions concerning mood, abnormal mental experiences, and the form of thinking."

Its validity and reliability have been documented in several clinical studies (Anthony et al., 1982; Folstein et al., 1975; Folstein and McHugh, 1979;). The first application of the MMSE in a large-scale community survey in the U.S. occurred in the Epidemiologic Catchment Area (ECA) Program sponsored by the National Institute of Mental Health at five sites: New Haven (Yale University), Baltimore (Johns Hopkins University), Durham (Duke University), St. Louis (Washington University), and Los Angeles (University of California, Los Angeles). Data from the Yale-New Haven study begun in the early 1980s have been published (Weissman et al., 1985).

H. Chinese Modification of the MMSE

The MMSE was translated into Chinese and back-translated by bilingual and bicultural P/AAMHRC staff, following the procedures described in Yu et al. (1987). Parallel translation and back-translation work was also conducted in China by a team of bilingual clinicians. The two versions were pre-tested on site (using 159 community residents in Chicago's Chinatown and 150 non-institutionalized elderly in Hong-Kou, Shanghai). The final Chinese version of the MMSE (called the CMMSE) used in our Jing-An survey of 5,055 elderly was constructed on the basis of findings obtained from both pretests. On the whole, most items in the instrument could be translated and used directly with Chinese respondents. However, on a few items, some modifications were required to make the instrument culturally appropriate for Shanghai.[5]

Results

A. Characteristics of the Elderly

Table 1 shows the demographic characteristics of the 5,055 respondents for whom we have CMMSE data. The unweighted data reflect sample characteristics, whereas the weighted data represent population estimates. Females comprise 56.6 percent of the total elderly population in Jing-An; males 43.5 percent (see the weighted % column). This distribution is not much different from the unweighted sample. Nearly one-quarter (23.2 percent) of the Jing-An population (or 26.8 percent of the total unweighted sample) are illiterate. Broken down by age, the illiteracy rate is highest in the oldest age group (about 27 percent). Even for the youngest age group, the illiteracy rate is quite high at 16 percent. The drop in illiteracy rate by more than 10 percent in each age category attests to the rapid social changes that China experienced between the end of the last century and the first quarter of this century. Women's education was one area where such rapid social change was most evident.

A large majority of the Jing-An elderly are married (72 percent), nearly a quarter (24.4 percent) are widowed, with divorced/separated or unmarried individuals each representing less than 2 percent. More than half of the population (56.6 percent) are living in some type of an extended family system where a non-nuclear family member is living together with the older person's spouse and children. Nearly one-third (32 percent) of the elderly live in strictly nuclear family households. This percentage decreases by age group from 39

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Table 1. Demographic characteristics for respondents 55 years and older: Shanghai, 1987

Characteristic	Unweighted 55-64 years	 65-74 years	 75+ years	 Sample	Weighted (%)
Sex	100.0 (1497)[a]	100.0 (2187)	100.0 (1371)	100.0 (5055)	100.0
Male	42.4 (634)	45.4 (993)	42.5 (583)	43.7 (2210)	43.5
Female	57.6 (863)	54.6 (1194)	57.5 (788)	56.3 (2845)	56.6
Age	N.A.	N.A.	N.A.	100.0 (5055)	100.0
55-64 years	N.A.	N.A.	N.A.	29.6 (1497)	29.6
65-74 years	N.A.	N.A.	N.A.	43.3 (2187)	43.3
75+ years	N.A.	N.A.	N.A.	27.1 (1371)	27.1
Education	100.0 (1496)	100.0 (2180)	100.0 (1354)	100.0 (5030)	100.0
Illiterate	15.8 (236)	26.6 (579)	39.5 (535)	26.8 (1350)	23.2
Si-shu/Saumeng ban	13.2 (198)	13.7 (299)	15.4 (208)	14.0 (705)	13.7
Elementary sch	23.5 (351)	24.5 (535)	19.4 (262)	22.8 (1148)	23.2
Jr,Sr, & Voc sch	36.8 (551)	25.3 (551)	17.6 (239)	26.7 (1341)	29.8
College & +	10.7 (160)	9.9 (216)	8.1 (110)	9.7 (486)	10.0
Marital status	100.0 (1495)	100.0 (2182)	100.0 (1353)	100.0 (5030)	100.0
Married	84.5 (1263)	66.9 (1460)	42.6 (576)	65.6 (3299)	72.0
Widowed	11.9 (178)	28.9 (631)	55.1 (746)	30.9 (1555)	24.4
Separated/Divorced	1.8 (27)	2.2 (49)	0.9 (12)	1.7 (88)	1.8
Single	1.8 (27)	1.9 (42)	1.4 (19)	1.7 (88)	1.8
Living arrangement	100.0 (1495)[a]	100.0 (2175)	100.0 (1333)	100.0 (5003)	100.0
Alone	3.5 (52)	6.7 (146)	8.7 (116)	6.3 (314)	5.4
Spouse/Child only	39.0 (583)	27.5 (599)	19.4 (259)	28.8 (1441)	32.0
Sp/Cd & Other Rel	54.4 (813)	59.1 (1285)	58.3 (777)	57.5 (2875)	56.6
Other Relatives[b]	1.4 (21)	4.0 (87)	9.1 (121)	4.6 (229)	3.5
Non-R/Other[c]	1.7 (26)	2.7 (58)	4.5 (60)	2.9 (144)	2.5
No. people in household	100.0 (1444)	100.0 (2038)	100.0 (1240)	100.0 (4722)	100.0
1	0.1 (1)	0.5 (9)	1.9 (23)	0.7 (33)	0.5
2	11.0 (159)	18.0 (367)	21.0 (261)	16.7 (787)	14.9
3	18.1 (261)	15.4 (314)	14.0 (174)	15.9 (749)	16.6
4	23.5 (339)	23.2 (473)	21.0 (260)	22.7 (1072)	23.0
5	24.3 (351)	23.0 (469)	23.1 (286)	23.4 (1106)	23.7
6+	23.0 (333)	19.9 (406)	19.0 (236)	20.6 (975)	21.4

a. Numbers in parentheses are frequencies.

b. Other relatives refers to relatives other than spouse and children.

c. Non-R/Other are households in which a non-relative is present. This category includes non-relatives living together, or spouse/children living with a non-relative, or relatives other than spouse/children living with a non-relative, or spouse/children living with other relatives plus a non-relative.

percent for the 55-64 year olds, to 27.5 for the 65-74 year olds, to 19.4 percent for the oldest age group. At the same time, the percentage living alone increases with each age group. As a whole, though, only 5.4 percent of the elderly population are living alone. Some 3.5 percent shares residence with relatives only (nuclear family members absent). In 2.5 percent of the population 55 years or older, a non-relative (such as a maid or hired caretaker) is present regardless of the family type. The percentage increase by age of the presence of a non-relative is an indication of the means by which individual Chinese families care for their elderly in the home rather than in institutionalized settings.

High fertility rates in the past means that China, in general, and Jing-An, in particular, are characterized by a high ratio of young to old people. This is also evident from the household structure of Jing-An residents where the percentage of multiple household members exceeds that of single or dual household members.

B. Employment and Economic Status

The majority (62.7 percent) of Jing-An residents 55 years or older are retired (Table 2). In general, the retirement age throughout China is 55 years for women and 60 years for men. By age 65, most elderly are retired, and this is reflected in Table 2. That the percent retired is lowest for the oldest age group is most likely an artifact of the higher survival rate found for women, many of whom are classified as "housewife" (a category which implies not looking for work and not working) in our survey and cannot be "retired."

Table 2. Employment and economic status of respondents 55 years and older: Shanghai, 1987

Characteristic	Unweighted				Weighted
	55-64 years	65-74 years	75+ years	Sample	(%)
Current employment status	100.0 (1467)[a]	100.0 (2074)	100.0 (1098)	100.0 (4639)	100.0
Retired	60.4 (886)	68.4 (1419)	55.8 (613)	62.9 (2918)	62.7
Working	21.7 (318)	2.3 (49)	1.2 (13)	8.2 (380)	12.1
Retired-working	12.3 (181)	7.6 (157)	1.3 (14)	7.6 (352)	9.2
Unemployed	1.1 (16)	2.5 (51)	6.4 (70)	3.0 (137)	2.3
Housewife	4.5 (66)	19.2 (398)	35.3 (388)	18.4 (852)	13.7
No. of household wage earner	100.0 (1486)	100.0 (2161)	100.0 (1338)	100.0 (4985)	100.0
0	9.2 (137)	15.3 (331)	15.2 (204)	13.5 (672)	12.3
1	14.0 (208)	16.5 (357)	18.7 (250)	16.3 (815)	15.6
2	30.6 (455)	34.1 (737)	32.2 (431)	32.6 (1623)	32.1
3+	46.2 (686)	34.1 (736)	33.9 (453)	37.6 (1875)	40.0
Household income	100.0 (1312)	100.0 (1916)	100.0 (1137)	100.0 (4365)	100.0
Less than 170 yuan	13.6 (178)	28.5 (545)	35.5 (403)	25.8 (1126)	22.1
171-270 yuan	21.3 (279)	26.0 (499)	25.2 (287)	24.4 (1065)	23.6
271-395 yuan	29.7 (390)	23.2 (444)	21.0 (239)	24.6 (1073)	26.1
400-4000 yuan	35.4 (465)	22.3 (428)	18.3 (208)	25.2 (1101)	28.2
Income per capita	100.0 (1260)	100.0 (1793)	100.0 (1044)	100.0 (4097)	100.0
Less than 35 yuan	5.2 (65)	9.5 (170)	12.2 (127)	8.8 (362)	7.7
36-55 yuan	12.3 (155)	21.6 (388)	26.3 (275)	20.0 (818)	17.6
56-85 yuan	45.3 (571)	45.5 (814)	42.3 (442)	44.6 (1827)	44.9
86-115 yuan	26.9 (339)	16.2 (290)	12.5 (130)	18.5 (759)	21.1
116+ yuan	10.3 (130)	7.3 (131)	6.7 (70)	8.1 (331)	8.7

a. Numbers in parentheses are frequencies.

Table 2 also shows that some 12 percent of the elderly have not yet retired. Another 9 percent of elderly who have retired from their regular job continue to work either part-time or full-time in another job, while about 2 percent of the elderly wanted to work but could not find work. Interestingly enough, this percentage increases with each age group from 1.1 percent among those 55-64 years old, to 2.5 percent in the next higher age group, and 6.4 percent in the oldest category.

Cross-tabulations by the number of wage earners in each household suggest that Jing-An's elderly appear to be financially well off in the sense that 40 percent are living in households with at least three wage earners (the elderly's spouse excluded), 32 percent with 2 wage earners, and 16 percent with one wage earner. Approximately 12 percent of those 55 years and older are living in a household with no wage earner at all.

The availability of wage earners ensures that the household income for many of these elderly is high. Therefore, household income does not offer as meaningful information about the elderly's socioeconomic status as does per capita income. The household income was divided by the number of persons living in each household, regardless of employment status, to arrive at income per capita. Table 2 shows that close to 8 percent of the elderly in Jing-An are living in households with a per capita income of 35 yuan or less per month -- the cut-off point for defining "poverty" in Shanghai, the largest metropolis in China whose cost of living is, of course, rather high.[6] Some 18 percent of the elderly are living in households with a per capita income of between 36 and 55 yuan, a range considered to be "below average" earnings in Shanghai. Another 45 percent live in households with a per capita income of 56-85 yuan; approximately 21 percent have a per capita income of 86-115 yuan, and about 9 percent may be considered "well-to-do" by Chinese standards, that is, their income exceeds 115 yuan.

C. Health, Personal Care, and Mobility

More than half of the Jing-An elderly population reported that their physical health is either good or excellent (Table 3). One-third perceived their health as fair, and about 15 percent are reportedly in poor health. When asked to compare themselves with others of the same age, half of the residents maintained that their health is not any worse or better. The percentage who saw themselves in worse health is the same as that found for those who saw themselves in better health than others.

Table 3. Health, personal care, and mobile activities of respondents 55 years and older: Shanghai, 1987

Characteristic	Unweighted				Weighted
	55-64 years	65-74 years	75+ years	Sample	(%)
Perception of physical health	100.0 (1496)[a]	100.0 (2184)	100.0 (1356)	100.0 (5036)	100.0
Poor	11.4 (171)	16.0 (349)	19.5 (264)	15.6 (784)	14.3
Fair	30.7 (459)	33.8 (738)	38.3 (519)	34.1 (1716)	32.9
Good	53.2 (796)	47.1 (1028)	38.7 (525)	46.6 (2349)	48.8
Excellent	4.7 (70)	3.1 (69)	3.5 (48)	3.7 (187)	4.0
Health compared to persons same age	100.0 (1496)	100.0 (2181)	100.0 (1352)	100.0 (5029)	100.0
Worse	23.1 (346)	27.5 (600)	28.3 (383)	26.4 (1329)	25.4
Same	54.3 (813)	47.6 (1038)	39.8 (538)	47.5 (2389)	49.8
Better	22.5 (337)	24.9 (543)	31.9 (431)	26.1 (1311)	24.8
Perception of mental/emotional health	100.0 (1467)	100.0 (2074)	100.0 (1097)	100.0 (4638)	100.0
Poor	4.7 (69)	5.7 (119)	5.7 (62)	5.4 (250)	5.2
Fair	21.1 (310)	27.1 (561)	32.6 (358)	26.5 (1229)	24.7
Good	65.5 (961)	59.1 (1226)	54.9 (602)	60.1 (2789)	61.8
Excellent	8.7 (127)	8.1 (168)	6.8 (75)	8.0 (370)	8.2
Memory problem	100.0 (1497)	100.0 (2185)	100.0 (1370)	100.0 (5052)	100.0
Yes	0.7 (10)	0.9 (20)	1.5 (20)	1.0 (50)	0.9
No	99.3 (1487)	99.1 (2165)	98.5 (1350)	99.0 (5002)	99.1
Personal care	100.0 (1496)	100.0 (2184)	100.0 (1356)	100.0 (5036)	100.0
Without help	98.7 (1476)	96.0 (2097)	85.0 (1152)	93.9 (4725)	95.7
Some difficulty	0.9 (14)	3.0 (66)	12.3 (167)	4.9 (247)	3.4
Only with help	0.2 (3)	0.7 (16)	1.8 (24)	0.8 (43)	0.6
Can't do at all	0.2 (3)	0.3 (5)	0.9 (13)	0.4 (21)	0.3
Mobile activities	100.0 (1496)	100.0 (2184)	100.0 (1356)	100.0 (5036)	100.0
Without help	96.7 (1446)	89.6 (1957)	64.5 (875)	85.0 (4278)	89.4
Some difficulty	2.3 (34)	7.7 (168)	21.8 (295)	9.9 (497)	7.1
Only with help	0.7 (11)	1.8 (40)	10.5 (143)	3.8 (194)	2.6
Can't do at all	0.3 (5)	0.9 (19)	3.2 (43)	1.3 (67)	0.9

a. Numbers in parentheses are frequencies.

Insofar as emotional or mental health is concerned, about three-fifths (62 percent) of the Jing-An elderly perceived themselves to be in good health; another 8 percent reported themselves to be in excellent health. At the opposite end, one quarter of the elderly viewed their emotional or mental health as fair, and 5 percent as poor. Nearly everyone (99 percent) has never talked to a doctor about any memory problems.

The majority of the elderly do not need help at all in their personal care (95.7 percent).[7] Some decline in personal care by age is evident when one compares the figures for persons 55-64, 65-74, and 75 years and over. Only three percent of the population 55 years or older indicated that they have some difficulty in personal care. As can be expected, the percentage increases with older age groups. About one percent needed help, a figure that is remarkably low but consistent with the overall positive picture of the elderly being rather healthy.

Close to 9 of every 10 elderly are mobile. That is, they can do the following things without help: take the bus by oneself, go out near home, climb stairs, get in and out of bed or chairs, and do shopping. The percentage who can do these tasks without help declines with age. The sharpest decline is found in the group most at risk for dementia (97 percent for the 55-64 years age group; 90 percent for the next older group, and 65 percent for the 75 years and older group).

Current Cognitive Impairment Prevalence Rates

Using a computer program developed for the Epidemiologic Catchment Area studies which produces the diagnoses of Cognitive Impairment[8] based on the DSM-III Criteria, we found that the rates of impairment increase with age for both males and females, as expected. Overall, some 4.1 percent of the elderly in Jing-An may be classified as having severe cognitive impairment while 14.4 percent are mild cases (Table 4). The rates for females are higher than for males by a ratio of 3.75 in the severe category, and 2.6 in the mild group. Such large excesses in rates due to gender differences is unusual and calls attention to the presence of sociocultural factors which influence Chinese women's performance on the cognitive impairment test, namely, the CMMSE. Because of women's traditionally low status in China, they continue to have less education than men, and old women suffer most from lack of education because of the socio-historical context of their early childhood socialization.

Table 4. Current prevalence of cognitive impairment for respondents 55 years and older by sex, age, and education[a]: Shanghai, 1987

	Unweighted										
	55-64 years			65-74 years			75+ years				
	Illiterate	Elementary	High School+	Illiterate	Elementary	High School+	Illiterate	Elementary	High School+	Total Sample	Weighted
Male											
Severe	0.0 (0)[b]	1.1 (2)	0.0 (0)	3.3 (3)	1.8 (7)	0.0 (0)	14.2 (16)	6.8 (16)	3.4 (8)	2.4 (54)	1.6 (54)
Mild	26.9 (7)	8.5 (16)	1.9 (8)	26.4 (24)	7.8 (31)	1.0 (5)	45.1 (51)	21.8 (51)	5.6 (13)	9.4 (208)	7.6 (208)
Female											
Severe	3.8 (8)	1.7 (6)	0.0 (0)	10.0 (49)	3.4 (15)	0.4 (1)	28.9 (122)	14.0 (33)	3.4 (4)	8.7 (247)	6.0 (247)
Mild	26.7 (56)	10.6 (38)	2.4 (7)	41.1 (202)	17.2 (75)	2.7 (7)	46.2 (195)	31.4 (74)	12.0 (14)	23.8 (676)	19.8 (676)
Both Sexes											
Severe	3.4 (8)	1.5 (8)	0.0 (0)	9.0 (52)	2.6 (22)	0.1 (1)	25.8 (138)	10.4 (49)	3.4 (12)	6.0 (301)	4.1 (301)
Mild	26.7 (63)	9.8 (54)	2.1 (15)	39.0 (226)	12.7 (106)	1.6 (12)	46.0 (246)	26.6 (125)	7.7 (27)	17.5 (884)	14.4 (884)

a. Education is broken down in three groups: Illiterate (illiterate); Elementary (si-shu & grade school); High School+ (vocational shchool, high school, and college).

b. Numbers in parentheses are frequencies.

The data in Table 4 also show that within each age group, the cognitive impairment rates vary by education. Under the mild impairment category, the pattern is quite consistent. The ratio of the rates for the illiterate compared to those with at least an elementary education is less than that of the rates for the latter group compared to those with high school education or more.

Among those who are classified as having severe cognitive impairment, the rates also vary by education but not in a consistent magnitude between education levels. However, this lack of a consistent trend may be due to the extremely small sample size which results from several layers of cross-classification in Table 4.

Table 5 shows the risk and consequences of cognitive impairment. Among men 75 years or older, the cognitive impairment rate is 7.2, but among women in the same age group, the rate is nearly three times higher (21.0). When the cognitive impairment data are cross-classified with education, the highest rate (11.4%) is found among the least educated. In the oldest age group, being able to read cuts the impairment rate by half from 25.8 percent for illiterates to 12.5 percent for the "semi-literate" (i.e., those educated under either si-shu or saumangban). The former is a system of education provided by private tutors to young children common before the first quarter of this century; the latter are mobile classes offered by the Communist regime during the 1950s to teach illiterate adults the essential literacy skills to survive in socialist China.) Education or, more precisely, the lack of education among large numbers of Chinese elderly women, substantially but not entirely accounts for the higher rate of cognitive impairment among females compared with males. The impact of education on the Mini-Mental Test is observable until the high school level. At that point, the rate between those who have a high school or equivalent education (3.4 for the age group most at risk of dementia), compared with those who have a college or higher education (3.6), is quite similar.

Table 5. Prevalence rates/100 cases of cognitive impairment according to demographic characteristics: Shanghai, 1987

Prevalence/100 Cases of Severe Cognitive Impairment

Characteristic	Unweighted				Weighted
	55-64 years	65-74 years	75+ years	Sample	(%)
Sex					
Male	0.3 (2)[a]	1.0 (10)	7.2 (42)	2.4 (54)	1.6
Female	1.7 (15)	5.5 (66)	21.0 (166)	8.7 (247)	6.0
Age					
55-64 years	N.A.	N.A.	N.A.	1.1 (17)	1.1
65-74 years	N.A.	N.A.	N.A.	3.5 (76)	3.5
75+ years	N.A.	N.A.	N.A.	15.2 (208)	15.2
Education					
Illiterate	3.4 (8)	9.0 (52)	25.8 (138)	14.7 (198)	11.4
Si-shu/Saumang ban	3.0 (6)	4.4 (13)	12.5 (26)	6.4 (45)	5.1
Elementary sch	0.6 (2)	1.7 (9)	8.8 (23)	3.0 (34)	2.0
Jr,Sr, & Voc sch	0.0 (0)	0.2 (1)	3.4 (8)	0.7 (9)	0.4
College & +	0.0 (0)	0.0 (0)	3.6 (4)	0.8 (4)	0.4
Marital status					
Married	0.9 (11)	2.7 (39)	10.1 (58)	3.3 (108)	2.3
Widowed	2.2 (4)	5.4 (34)	18.8 (140)	11.4 (178)	9.1
Sep/Div	0.0 (0)	0.0 (0)	0.0 (0)	0.0 (0)	0.0
Single	3.7 (1)	4.8 (2)	5.3 (1)	4.6 (4)	4.3
Living arrangement					
Alone	0.0 (0)	0.0 (0)	0.0 (0)	0.0 (0)	0.0
Spouse/Child only	0.9 (5)	2.5 (15)	13.5 (35)	3.8 (55)	2.5
Sp/Cd & Other Rel	1.1 (9)	3.9 (50)	15.7 (122)	6.3 (181)	4.4
Other Relatives[b]	0.0 (0)	2.3 (2)	16.5 (20)	9.6 (22)	7.3
Non-R/Other[c]	7.7 (2)	5.2 (3)	15.0 (9)	9.7 (14)	8.7

a. Numbers in parentheses are frequencies.

b. Other relatives refers to relatives other than spouse and children.

c. Non-R/Other are households in which a non-relative is present. This category includes non-relatives living together, or spouse/children living with a non-relative, or relatives other than spouse/children living with a non-relative, or spouse/children living with other relatives plus a non-relative.

Multiple Logistic Regression

Multiple logistic regression was used to examine, within each age group, the nature of the association between presence of a cognitive impairment and educational level controlling for sex, with educational level coded ordinally (0=illiterate; 1=Si-Shu or Saumangban; 2=elementary; 3=high school or greater). The results showed that within each of the three age groups, educational attainment has a highly significant inverse relationship with prevalence of cognitive impairment (severe vs. others) even when sex was controlled for in the logistic regression analysis ($X^2=12.84$, $p<.001$ in the 55-64 group; $X^2=38.75$, $p<.001$ in the 65-74 group; $X^2=51.92$, $p<.001$ for 75+ group). On the other hand, when educational attainment was controlled for in the logistic regression model, sex was significantly associated with prevalence of cognitive disorders for the two older age groups ($X^2=5.60$, $<.05$ for 65-74 age group; $X^2=13.57$, $p<.001$ for 75 years and over), but not for the youngest group of elderly ($X^2=.61$, $p=.44$ for the 55-64 years age group).

Impairment by Marital Status

A higher rate of impairment is found among the widowed (18.8) than among the married persons (10.1) in the age group 75 years and older. Shifting to the weighted percent column, we find that the rate of severe cognitive impairment is highest for the group living in a household with a non-relative (either a maid or hired caretaker is present (8.7), followed by households where only a non-nuclear family member is present (7.3). Nuclear family households have the lowest rate of severely impaired elderly. This finding suggests that co-residence with non-relatives or non-nuclear family members may be a coping strategy for families of the non-institutionalized elderly in Jing-An.

Impairment by Economic Status

Arranging the data by economic status, we observe that the cognitive impairment rate is highest in each age group for the lowest-income category, households with less than 35 yuan per capita income (Table 6). The weighted data show a consistent drop in severe cognitive impairment rate by income until the highest income group, but the rate by age does not show a consistent trend.

Table 6. Prevalence rates/100 cases of severe cognitive impairment according to economic status: Shanghai, 1987

	Prevalence/100 Cases of Severe Severe Cognitive Impairment				
	Unweighted				Weighted
Characteristic	55-64 years	65-74 years	75+ years	Sample	(%)
No. of household wage earner					
0	0.7 (1)[a]	3.0 (10)	16.7 (34)	6.7 (45)	4.7
1	1.0 (2)	3.6 (13)	13.2 (33)	5.9 (48)	4.2
2	0.9 (4)	3.0 (22)	12.5 (54)	4.9 (80)	3.4
3+	1.0 (7)	3.7 (27)	17.0 (77)	5.9 (111)	3.8
Household income					
Less than 170 yuan	1.7 (3)	3.1 (17)	12.4 (50)	6.2 (70)	4.8
171-270 yuan	0.4 (1)	3.0 (15)	13.9 (40)	5.3 (56)	3.5
271-395 yuan	0.8 (3)	2.9 (13)	12.6 (30)	4.3 (46)	2.8
400-4000 yuan	0.4 (2)	2.6 (11)	20.7 (43)	5.1 (56)	2.9
Income per capita					
Less than 35 yuan	3.1 (2)	5.9 (10)	19.7 (25)	10.2 (37)	8.0
36-55 yuan	1.3 (2)	1.8 (7)	12.7 (35)	5.4 (44)	3.9
56-85 yuan	0.4 (2)	3.7 (30)	17.0 (75)	5.9 (107)	3.7
86-115 yuan	0.9 (3)	1.4 (4)	14.6 (19)	3.4 (26)	2.2
116+ yuan	0.0 (0)	3.8 (5)	12.9 (9)	4.2 (14)	2.5

a. Numbers in parentheses are frequencies.

Impairment and Health-Related Problems

An examination of the response pattern in Table 7 suggests that there is a tendency for those elderly who rated their health on either extreme (that is, "poor" or "excellent") to fall in the severe category of the cognitive impairment measure. Just how much clinical significance one should attach to this finding is far from clear. On the other hand, the percentage of severe cognitive impairment is higher among those who claim their health is "worse" than others, compared to those who thought their health was the same as, or better than, others. In the age group 75 years and older, the next larger percentage of severe cognitive impairment is found among those who rated their health as "better" than others.

Among the elderly who have spoken to a doctor about their memory problems, some 18 percent have severe cognitive impairment (Table 7). Among those who cannot care for themselves, 66 percent are classified as severely impaired by the CMMSE (see Table 7). In contrast, among those who can care for themselves, only 3 percent evidenced severe cognitive impairment.

Likewise, the percentage with severe cognitive impairment increases with the proportion of elderly who report difficulty with mobility. Some 39 percent of those who cannot move around are classified as having severe cognitive impairment. Another 30 percent of those who are mobile only with help, and 16 percent of those who reported some difficulty are also severely impaired, cognitively. Only about 2 percent of those who needed no assistance whatsoever have severe cognitive impairment scores.

Table 7. Prevalence rates/100 cases of cognitive impairment according to self-perceived health status, level of personal care and mobile activities: Shanghai, 1987

	Prevalence/100 Cases of Severe Cognitive Impairment				
	Unweighted				Weighted
Characteristic	55-64 years	65-74 years	75+ years	Sample	(%)
Perception of physical health					
Poor	3.5 (6)[a]	5.7 (20)	23.5 (62)	11.2 (88)	8.5
Fair	0.6 (3)	3.9 (29)	14.1 (73)	6.1 (105)	4.2
Good	0.5 (4)	2.2 (23)	10.1 (53)	3.4 (80)	2.2
Excellent	4.3 (3)	4.4 (3)	25.0 (12)	9.6 (18)	7.0
Health compared to persons same age					
Worse	2.3 (8)	5.5 (33)	20.1 (77)	8.9 (118)	6.5
Same	0.6 (5)	2.7 (28)	10.2 (55)	3.7 (88)	2.5
Better	0.9 (3)	2.4 (13)	14.8 (64)	6.1 (80)	4.1
Memory problem					
Yes	20.0 (2)	5.0 (1)	35.0 (7)	20.0 (10)	18.1
No	1.0 (15)	3.5 (75)	14.8 (200)	5.8 (290)	4.0
Personal care					
Without help	1.0 (15)	2.9 (61)	10.9 (126)	4.3 (202)	3.0
Some difficulty	0.0 (0)	10.6 (7)	30.5 (51)	23.5 (58)	20.0
Only with help	0.0 (0)	25.0 (4)	45.8 (11)	34.9 (15)	29.8
Can't do at all	33.3 (1)	60.0 (3)	92.3 (12)	76.2 (16)	66.1
Mobile activities					
Without help	0.8 (12)	2.0 (39)	6.5 (57)	2.5 (108)	1.9
Some difficulty	5.9 (2)	14.9 (25)	20.7 (61)	17.7 (88)	16.1
Only with help	9.1 (1)	15.0 (6)	41.3 (59)	34.0 (66)	30.1
Can't do at all	20.0 (1)	26.3 (5)	53.5 (23)	43.3 (29)	38.7

a. Numbers in parentheses are frequencies.

Discussion

Determination of the prevalence of dementia, a diagnosis that requires evidence of both progressive functional and cognitive impairment, awaits completion of the clinical evaluation of the cognitively impaired respondents.[9] The present study is informed by the knowledge that diagnoses of many of the important dementing diseases can be confirmed or denied with certainty only at autopsy. In the absence of the latter data and as we await the results of clinical evaluations from the field, computer-generated diagnoses of DSM-III-like dementia using a SAS-mainframe program developed for the Epidemiologic Catchment Area (ECA) studies are utilized in here to report our preliminary findings.

The reader is warned against the danger of equating cognitive impairment symptoms generated from screening scales such as the MMSE with the psychiatric diagnoses of cognitive impairment or dementia. Computer-generated diagnosis is not a substitute for intensive clinical evaluations by well-trained psychiatrists. Furthermore, it is uncertain at this time as to what mild cognitive impairment means. Whether or not all such cases proceed to a moderate or severe dementia remains to be studied more systematically (Henderson and Huppert, 1984). Available data suggest the possibility that persons with limited intelligence or education may be mistakenly classified as cases of mild dementia (Anthony et al., 1982; Bergmann et al., 1971).

The Shanghai survey data tentatively indicate that the prevalence of cognitive impairment appears to be somewhat higher but may not be substantially different from that reported for the Yale-New Haven elderly (Weissman et al., 1985). A comparative analysis of both the Yale-New Haven and the Shanghai data will be made and presented in a separate paper. Meanwhile, the most remarkable findings from our community survey of 5,055 non-institutionalized persons 55 years or older are their relative well-being, and the gender differences in illiteracy and cognitive impairment rates.

In summary, the majority of elderly persons are not financially strained. Most are married, in good physical and mental health, have never talked to a doctor about a memory problem, do not need help in personal care, and are not house-bound. However, as Weissman et al. (1985) pointed out in their paper, these sociological survey findings must be balanced by the clinical/epidemiologic perspective, because the same dataset calls attention to the relative risk of severe cognitive impairment with increasing age, and to the physical functioning difficulties of the severely impaired individuals, males or females.

Although more women survive at older ages -- outnumbering men by a ratio of 1.3 to 1, more of them are also classified in the severe cognitive impairment category when the CMMSE was used as the yardstick for classifying the respondents. Again, this finding is nearly identical to that found in the Yale-New Haven study.

Some 23 percent of persons 55 years or older never received any education. Among those 75 years or older, the figure is 40 percent. The overwhelmingly high cognitive impairment rates found for the least educated persons reported by other researchers in the United States (Anthony et al., 1982) is also replicated in Shanghai. Even the Shanghai finding that the CMMSE scores of elderly who have had elementary education or less is distinctly different from those who have had high school or more education is similar to that found in the United States. All these findings point up a universal constancy in the way the MMSE, with appropriate modifications, behaves across cultures, and highlight the significant difference that basic educational deficits make in human cognitive functioning as measured through tests such as the CMMSE.

When we discovered the extent of the education-confound upon the scores, we carried out an intermediate intensive clinical evaluation of a subset (N=190) of the sample. This subset was selected to help us find the cutoff scores on which to base the remaining clinical evaluations. Until the ongoing intensive evaluation of an additional 450 subjects is completed, we will not be able to determine the prevalence of dementia in the overall sample. In two separate papers that are under preparation (Katzman et al., 1988; Yu et al., 1988), the authors will describe the procedures they have used to determine the appropriate cut-off point for each education level, and report their findings on the impact of education on the Chinese Mini-Mental Status Examination in the Shanghai Study of Dementia.

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COGNITIVE IMPAIRMENT AMONG THE ELDERLY IN SHANGHAI, CHINA

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Endnotes

1. The urban sector of Shanghai, which consists of 12 districts, has a population of 7 million. However, Metropolitan Shanghai-- an area which consists of the 12 city districts (the urban sector) and 10 surrounding counties (the suburban sector) -- has a population of 12 million.

2. Ethel Shanas was the Co-organizer of the delegation whose members came from various universities in the United States. The 1984 visit resulted in discussions of the possibility of collaborative research among three institutions: SIMH, P/AAMHRC, and ADRC. On both sides of the Pacific Ocean, these discussions were followed by year-long planning of research strategies, application for funding, and training and recruitment of technical personnel to increase each collaborating unit's capability in handling large-scale survey data on personal computers as well as the mainframe computer.

3. In Jing-An, each Neighborhood Group consists of from 1 to 100 households. Printouts were prepared by the study team numerically identifying each Neighborhood Group within each Neighborhood Committee and Street Committee.

4. See Levy and Lemshow (1980).

5. The CMMSE is available upon request from the first author. Examples are: the repetition of "No if's, and's, or but's" and say W-O-R-L-D backwards. Conceptually equivalent tasks were found for these items. Because of the high illiteracy rate among the elderly Chinese, particularly women, the test item "Write a sentence" was changed to "Say a sentence."

6. Workers whose incomes fall below that amount are eligible for income supplement at the Shanghai Psychiatric Hospital, for instance, as in most other work units in the city.

7. We define personal care as the ability to eat one's meals, dress and undress by oneself, groom oneself, bathe or wash oneself, cut one's toe-nails, and use the toilet in time.

8. The computer program uses two parallel scoring systems to classify the elderly's level of impairment on the basis of total number of errors. The latter has a maximum of 30 correct responses. One scoring system treats unanswered questions as errors and the other as missing values. Each of these two systems classifies the respondent as having a severe cognitive impairment if the number of errors is 13 or higher, and mild disorder if the scores are 7-12 errors. When the two scoring systems agree with each other, the presence of cognitive impairment is considered to be "definite." When they disagree, cognitive impairment is labelled as "possible."

9. Moreover, the very important question of whether low education is a confound because the group includes some retarded individuals or because the respondents have never had the life experiences needed to answer certain questions versus the possibility that low education or mental retardation may be associated with an increase in prevalence of dementia (for example, poor childhood nutrition could lead to retardation and might be a risk factor for later life dementia) cannot be answered with the data on hand.

References

Anthony, J.C., Niaz, U., & LeResche, L.A. et al. (1982). Limits of the 'Mini-Mental State' as a screening test for dementia and delir-ium among hospital patients. *Psychological Medicine 12* , 397-408.

Bergmann, K., Kay, D.W.K., & Foster, E.M. et al. (1971). A follow-up study of randomly selected community residents to assess the effect of chronic brain syndrome and cerebrovascular disease Pp. 856-865 in *New Prospects in the Study of Mental Disorders in Old Age*. Proceedings of the VT World Congress of Psychiatry, Mexico. Amsterdam: Excerpta Medica.

Burnam, M. Audrey, Hough, R.L., & Escobar, J.I. et al. (1987). Six-month prevalence of specific psychiatric disorders among Mexicans and Non-Hispanic Whites in Los Angeles. *Archives of General Psychiatry 44* (August), 687-694.

Chen, X.S. et al.(1987). An epidemiologic investigation of mental disorders of the aged in the urban district of Beijing. *Chinese Journal of Neurology and Psychiatry 20* (3), 145-150.

DePaulo, J.R. & Folstein, M.F. (1978). Psychiatric disturbances in neurological patients: detection, recognition, and hospital course. *Annual of Neurology 4* , 225-228.

Folstein, F., Folstein, S.E. & McHugh, P.R., (1975). Mini-Mental State: A practical method for grading the cognitive state of patients for the clinicians. *Journal of Psychiatric Research 12*, 189-198.

Folstein, M.F. & McHugh, P.R. (1979). Psychopathology of dementia: Implications for neuropathology Pp. 17-30 in R. Katzman (Ed.), *Congenital and Acquired Cognitive Disorders*. New York: Raven Press.

Henderson, A.S. & Huppert, F.A. (1984). The problem of mild dementia. *Psychological Medicine 14,* 5-11.

Jarvis, E. (1971). Insanity and idiocy in Massachusetts: Report of the Commission on Lunacy, 1855. Cambridge, MA: Harvard University Press.

Katzman, R., Zhang, M.Y., & Qu, G.Y. et al. (1988). A Chinese illiteracy in a Shanghai dementia survey. Submitted to *Journal of Clinical Epidemiology.*

Kuang, P.G. et al. (1981). A survey of senile disturbance in Wuhen City in 1981. *Chinese Journal of Epidemiology 5* (2), 95-99.

Lemkau, P., Tietze, C. & Cooper, H. (1941). Mental hygiene problems in an urban district. *Mental Hygiene 25,* 624-646.

Lemkau, P., Tietze, C. & Cooper, H. (1942a). Mental hygiene problems in an urban district, Second Paper. *Mental Hygiene, 26,* 100-119.

Lemkau, P., Tietze, C. & Cooper, H. (1942b). Mental hygiene problems in an urban district, Third Paper. *Mental Hygiene, 26,* 275-288.

Lemkau, P., Tietze, C. & Cooper, H. (1942c). Complaint of nervousness and the psychoneuroses. *American Journal of Orthopsychiatry, 12,* 214-223.

Lemkau, P., Tietze, C. & Cooper, H. (1943). Mental hygiene problems in an urban district, Fourth Paper. *Mental Hygiene 27,* 279-295.

Levy, Paul & Lemeshow, S. (1980). *Sampling for health Professionals*. Belmont, California: Lifetime Learning Publications.

Lin, K.M. & Kleinman, A. (1981). Overview of mental disorders in Chinese cultures: Review of epidemiological and Chinese studies. Pp. 237-273 in A. Kleinman and Lin, T.Y. (eds.), Normal and Abnormal Behavior in Chinese Culture. Boston: D. Reidel Publishing Company.

Liu, William T., Xu, C.L., Zhang, M.Y. et al. (1984). The 1983 Shanghai psychiatric epidemiologic survey: Research objectives, procedures, and field operations. Working Paper No. 103b. Chicago: Pacific/Asian American Mental Health Research Center.

Myers, J. K. et al. (1984). Six-month prevalence of psychiatric disorders in three communities. *Archives of General Psychiatry, 41* (October), 959-967.

Robins, L. et al. (1984). Lifetime prevalence of specific psychiatric disorders in three sites. *Archives of General Psychiatry 41* (October), 959-967.

Roth, W.F., & Luton, F.H. (1943). The mental health program in Tennessee. *American Journal of Psychiatry, 99,* 662-675.

Wang, Chang-Hua et al. (in press). Alcohol use, abuse and dependency in Shanghai. To appear in John Helzer et al. (Eds.), *Cross national studies of alcoholism*. London: Oxford University Press.

Wang, Chang-Hua (1983). Psychiatric epidemiologic surveys in China. Unpublished manuscript, in Chinese. Shanghai: Shanghai Psychiatric Hospital.

Weissman, M.M. et al. (1985). Psychiatric disorders (DSM-III) and cognitive impairment among the elderly in a U.S. urban community. *Acta Psychiatrica Scandinavica 71*. 366-379.

Wing, J.D. et al. (1977). Reliability of the PSE (ninth edition) used in a population survey. *Psychological Medicine, 7,* 505-516.

Wing, J.K. (1983). The use and misuse of the PSE. *British Journal of Psychiatry,1 43*, 111-117.

Wing, J.K. (1986). Describing and classifying psychiatric symptoms: The PSE-CATEGO system. Pp. 429-448 in M.M. Weissman, J. K. Myers, and C.E. Ross (Eds.), *Community surveys of psychiatric disorders*. New Brunswick, N.J.: Rutgers University Press.

Yu, Elena, et al. (1987). Translation of instruments: Procedures, issues and dilemmas. Pp. 75-86 in William T. Liu (Ed.), *The Pacific/Asian American Mental Health Research Center. A Decade Review of Mental Health Research, Training, and Services. A Report to the National Institute of Mental Health*. Chicago, P/AAMHRC.

Yu, Elena, S.H. et al. (1988). A comparison of Chinese and American response patterns to the MMSE. Paper under preparation.

CHAPTER 6

INTERGENERATIONAL RELATIONS IN CONTEMPORARY CHINA: DESCRIPTIVE FINDINGS FROM SHANGHAI

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Introduction

With over one billion people, China accounts for nearly a quarter of the world's population. It also has the largest population of elderly (60 and over) living under one government (approximately 80 million). These elderly make up approximately 8 percent of China's population (Banister, 1984). In the U.S., the same age group makes up 15.8 percent of the total population (U.S. Census, 1983). In fifteen years (by the year 2000), China expects a 63 percent increase in the size of its elderly population. The projected 130 million elderly will then constitute 11 percent of China's numbers. U.S. projections reflect similar growth, with those over 60 expected to make up about 20 percent of the population by the year 2000. China leads developing nations in longevity. Life expectancy has increased from 43 years in 1949 to 73 years -- testimony to the great strides the country has made in the area of public health. With this increased life expectancy comes the challenge of providing support for the elderly. Security for China's elderly derives from three sources: pensions, employment and family care. Government pensions ranging from 60 percent to 90 percent of salary are available to state workers who make up 80 percent of the urban labor force. Yet, current pension coverage in urban areas is far from universal. Of the 18 million people of retirement age in the cities, only 8 million (45 percent) received pensions in 1981 (Goldstein & Goldstein, 1984). In rural China, pensions are much less common. The estimated 3 million retirees who worked in rural collective enterprises receive small pensions. However, for the vast majority of elderly in rural areas pension support is not available. Instead, they rely upon a combination of marginal employment and dependence upon sons (Davis-Friedmann, 1983). Introduction of the production responsibility system in the late 1970s encouraged establishment of private gardens and raising of private livestock. By engaging in these enterprises the rural elderly contribute substantially to their families' standard of living. They also take on auxiliary jobs such as orchard watchman, stockman, and scavenger (Liang, 1985).

In both urban and rural areas the family continues to serve as the main support in old age. In fact, the constitution of the People's Republic of China specifically states that children have an obligation to provide for their parents. Those who fail to do so may be subject to criminal penalties (Zhu, 1985). The administrative structure of Chinese government includes resident committees (danwei), which help families meet this mandate by mediating disputes (see Parish & Whyte, 1984, for a description of the mediation process). Traditionally, sons assume primary responsibility for their parents. When a woman married she became part of her husband's household. Today, most of China's elderly live in three-generation households, usually with a son and daughter-in-law and their children. The elderly are important contributors to the household economy, assuming responsibility for child-rearing, cooking, cleaning and tending domestic animals.

The study reported here was conducted to investigate three components of China's old age support system: pensions, employment and family care, with particular emphasis on intergenerational relations. The theoretical framework was drawn from exchange theory. We investigated the norm of reciprocity as it is evidenced in the Chinese cultural context. Specific questions considered include:

1. In what way do the elderly contribute to the economies of three-generation households? How does this contribution influence intergenerational relations? We know in general terms the sorts of activities the elderly engage in. This study took a more detailed look at their contribution to maintaining harmony within the household.

2. Within three-generation households, do all generations have similar expectations and values regarding care of the frail elderly? If not, how do they differ? China differs from industrialized nations in its low proportion of "old-old". Proportions of elderly 75-79 years of age and 80 and over are 11 percent and 7 percent respectively, compared to 13 percent and 15 percent in the U.S. Thus fewer families have confronted the need to provide care to a frail elder. We anticipate that in coming years more families will face this challenge. This survey of attitudes of different generations will prove helpful, projecting possible difficulties in this area.

3. What is the specific content of intergenerational disputes and how are they resolved? We suspect that the norm of reciprocity is important in this context, and that disputes arise most often when elderly do not and have not contributed to their children's households. China's strength lies in its well-established system of family care for the elderly. This study was designed to contribute to both our theoretical understanding of the family and our ability to intervene in intergenerational disputes.

Method

Sample

This research was conducted in Shanghai, a city of 12 million. The sample included three generation households registered in two neighborhood committees: Jiang Er and Zhong Yi. In the Jiang Er neighborhood there are 760 households, with a total population of 2,608. The Zhong Yi neighborhood includes 575 households with 1,980 residents. A random sample of 58 households was drawn, and interviews were conducted with members of each generation. Children under the age of 10 were not included in the sample. A total of 256 individuals participated in these interviews.

Seventy-three grandparents were interviewed. In this (G1) generation the mean age was 71 years, with a range of 59 to 92. Most (67 percent) of the grandparents surveyed were women. The most common occupation was worker (33 percent), followed by housewife (25 percent), clerical worker (18 percent), cadre (10 percent), intellectual (8 percent), and professional (6 percent).

A total of 113 parents were interviewed. The mean age for parents (the "G2" generation) was 44 years, with a range of 33 to 63. This group was evenly divided between men (50 percent) and women (50 percent). The most usual occupations were professional (23 percent) and worker (23 percent), followed by cadre (20 percent), intellectual (18 percent), and clerical (15 percent).

Seventy grandchildren were interviewed. Their mean age was 15 years, with a range of 10 to 26. Grandchildren were labelled the "G3" generation.

Instruments

Separate interview schedules were prepared for each generation. In addition to demographic information, the instruments collected data regarding intergenerational assistance and gift-giving, daily activities, experiences and expectations regarding elder care, social contacts, and intergenerational conflict. In addition, both parent and grandparent generations responded to the Center for Epidemiological Studies - Depression (CES-D) scale.

An attitude scale developed by Elaine Brody and her colleagues (1983) was administered to members of all three generations. The scale includes 46 statements, and respondents were asked to indicate their response using a five-point Likert scale, ranging from "strongly disagree" (1) to "strongly agree" (5). A principal components analysis was performed to determine the major dimensions of this scale. The analysis resulted in four components with eigenvalues greater than

1.83, accounting for 25.4 percent of the total variance. These components were rotated to the varimax criterion. The four factors reflected attitudes towards: receiving and giving help, family care of sick elderly, social change, and personal control. Using a .40 cut-off point, 28 (61 percent) of the 46 items loaded onto these four factors. Analysis of variance was then used on the 28 items to identify those on which there were significant differences between generations ($p < .05$).

Interviews

The interviewers were psychiatrists and nurses working at the Shanghai Institute of Mental Health. Interviewer training sessions took three days, with a U.S researcher (A.S. Barusch) serving as training faculty. Training focused on communication techniques for use with elderly and young children, as well as standardization of recording. Several rounds of mock interviews were conducted.

Pilot interviews were conducted with 20 families under the supervision of the U.S. researcher. These interviews provided data for use in establishing codes for open-ended questions. All interviews were conducted in respondents' homes between May and July, 1989. Completed interview booklets submitted by the interviewers were checked by supervisors to detect missed questions, illegible codes and illogical or inconsistent responses. The data were then entered, using a validation program set up specifically for this study, on a PC.

Results

Grandparents' Contribution

In what way do grandparents contribute to the household economies of three-generation households? Table 1 presents responses of each generation to an open-ended question regarding the grandparents' contribution. Grandparents were asked "What do you do to help your children and grandchildren?" and both children and grandchildren were asked "What does your grandparent do to help you?" Responses to the question were recorded in the order given. Results for the first answer (seen as the "primary" response) are considered here.

The table reveals strong consensus regarding the primary contribution of grandparents. All three generations report that most grandparents help by doing kitchen work, such as preparing food and washing dishes. A few discrepancies are worth noting. First, grandparents are more likely than other family members to mention cleaning. This may be because others are unaware of the amount of time spent cleaning. Second, although both grandparents and parents list help with children as a primary form of assistance, grandchildren do not. Grandchildren are more likely to give responses coded as "other," suggesting need for additional content analysis. Since the majority of grandparents in this sample (67 percent) report receiving a pension, it is interesting that so few report that grandparents help by giving money or doing shopping. What do grandparents do with their pensions?

Table 1
What Do Grandparents Do to Help?

	Grandparents' Response	Parents' Response	Grandchildrens' Response
		Percentages	
Nothing	16	15	17
Clean house			
Floor/room	23	7	3
Laundry	3	4	7
Heavy repair	0	1	1
Help with children	11	20	0
Shopping	4	5	3
Kitchen work	36	40	47
Give money	1	0	0
Provide house/food	3	4	1
Past assistance	1	2	3
Other	1	3	17

Percentages indicate proportion of generations who listed each task as their primary response.

Expectations Regarding Elder Care

Who will take care of grandparents?

Table 2 presents the views of each generation on who would care for the grandparents if they were to become sick or injured. All three generations seem to agree that primary responsibility would reside with the middle (parent) generation. However, there is some disagreement about the role of the grandchildren. Whearas grandparents and parents are unlikely to list them as a source of care, 14 percent of grandchildren responded that they would do so. Grandchildren are also less likely than other generations to view the spouse of the grandparent as a source of care. None of the generations anticipated relying on government or formal sources of care.

When we asked respondents why the person would provide the care, the older (parent and grandparent) generations were most likely to refer to duty or obligation. Grandchildren, on the other hand were most likely to refer to tradition and the person's role in the family saying, for example, "Because he/she is the son." There was relatively little reference to reciprocity, or the need to discharge a debt or repay a favor.

Who will take care of grandchildren?

Table 3 presents the responses of grandchildren when they were asked: "When you are old, who will take care of you if you become hurt or sick?" Grandchildren were much less likely than the grandparents to anticipate relying on their children. Where the vast majority (95 percent) of grandparents expected a member of the middle generation to care for them, only 43 percent of grandchildren did so. In fact, grandchildren's responses to this question were quite diverse. Some (7 percent) expected their parents to provide care. Others expected to rely on a spouse (19 percent) or sibling (4 percent). One of the more creative respondents expected to be cared for by a robot!

Table 2
Who Will Take Care of Grandparents?...And Why?

Who?	Grandparents' Perspective (n = 73)	Parents' Perspective (n = 113)	Grandchildrens' Perspective (n = 70)
	Percentages		
Don't Know	0	0	0
Government	1	1	0
Daughter or Son-in-Law	40	29	13
Son or Daughter-in-Law	45	60	49
Spouse	8	4	1
Other relative	0	0	4
Friends/neighbor	0	0	0
Grandchildren	3	1	14
No One	0	0	1
Other	0	5	17

Why?	(n = 73)	(n = 133)	(n = 16)
	Percentages		
Not Sure	0	0	0
Duty/Obligation	25	36	19
Tradition	3	4	25
Role	19	13	25
No one else can	11	11	19
Good Relationship	10	4	0
Live together	16	20	0
Reciprocity	6	5	6
Only child	0	3	0
It's his/her job	3	2	0
Other	8	4	6

Table 3
Who Will Take Care of the Grandchildren?

(n = 70)

	Percentages
No One	6
Spouse	19
Children	43
Parents	7
Government	4
Other Family Member	1
Sibling	4
Servant	3
Other (Robot, etc.)	3
Don't Know	10

Intergenerational Disputes

In order to learn about the specific content of intergenerational disputes, each respondent was asked whether he or she ever argued with other members of the family. Those who indicated that they did have arguments were asked what they argued about. Table 4 presents these results.

Grandparents seldom report arguing with other family members. If they do have arguments, they are most likely to be with grandchildren or daughters. Twenty-two percent of grandparents reported that they argued with at least one grandchild. Sixty-nine percent of those who argued did so with a male grandchild. It is interesting to note that a much higher proportion (51 percent) of grandchildren report having arguments with their grandparents. We suspect that this discrepancy is due to cohort differences in respondents' reactions to the interview situation. This difference is also reflected in responses of the middle (parent) generation. Nearly half (48 percent) of parents report having arguments with the grandparents, while only twenty-two percent of grandparents reported arguments with a daughter or daughter-in-law; and nineteen percent reported arguments with a son or son-in-law.

Table 4 presents the topics of arguments as reported by grandparents, parents, and grandchildren. From the grandparents' perspective, most arguments tend to focus on what the other person (either grandchild, son, or daughter) should do or be. Arguments about general values or beliefs are most likely with the daughter or daughter-in-law. Grandparents and adult children are also quite likely to disagree about how grandchildren should be raised. Nineteen percent of grandparents reported having these disputes with daughters, and twenty-one percent with sons.

Notably, thirty-five percent of parents report arguing with the grandparents about how grandchildren should be raised. In fact, from the parents' perspective, this is the most common topic of disagreement. It is followed by general beliefs and values (15 percent) and what the grandparent should do or be (11 percent).

Grandchildren report that the most common topic of disagreement with their grandparents is what the grandchildren should do or be (24 percent), followed by general beliefs and values (15 percent) and television (15 percent).

Table 4
Intergenerational Conflict: What do Grandparents Argue About

Topic	Grandparents' Perspective: With Grandchildren (n = 16)	Grandparents' Perspective: With Daughter or Daughter-in-Law (n = 16)	Grandparents' Perspective: With Son or Son-in-Law (n = 14)	Parent's Perspective (n = 36)	Grandchildren's Perspective (n = 54)
	Percentages				
He/she is critical of me	0	0	0	9	0
T.V.	0	0	0	15	0
What Grandchildren should do or be	75	0	0	24	0
What Grandchildren should have	0	0	0	0	0
What Grandparent should do or be	0	0	0	12	11
What Grandparent should have	0	0	0	3	2
General beliefs/ values	13	13	7	15	15
What parent should do or be	--	25	50	0	4
What parent should have	--	6	7	0	7
Grandchildren (i.e. how to raise them)	--	19	21	0	35
Other	12	37	14	21	35
Not Sure	0	0	0	0	2

Percents indicate proportion of those who reported having arguments.

General Attitudes Towards Aging and Elder Care

Table 5 presents results from the attitude scale developed by Elaine Brody and her colleagues (1983). Items in the table are those which both loaded onto the four factors identified in this study and revealed statistically significant intergenerational differences. These differences emerged on each of the four factors.

When contemporary social changes are considered, the difference between grandparent (G1) and grandchild (G3) generations is striking. Both agreed that women should be more involved as leaders, but grandchildren were more likely to agree than grandparents. Grandchildren were less likely than grandparents to agree that adult children do not take as much care of elderly parents nowadays as they did in the past. Finally, whereas grandparents tend to disagree with the view that old people have too much power, the majority of grandchildren tend to agree. The middle (G2) generation more closely resembled grandparents on two of the items, but tended to agree with grandchildren that old people have too much power.

Table 5
Attitudes of Three Generations on Family support and Care for Elderly

	Percent Indicating Agreement			
	G1	G2	G3	p*
		(n=73)	(n=113)	(n=70)
Social Change				
1. Women should be more involved as leaders in solving today's social problems.	73.6	76.1	91.4	.02
2. Nowadays, adult children do not take as much care of their elderly parents as they did in past generations.	82.1	89.5	60.0	.00
3. Old people have too much power in business and politics.	32.9	59.3	54.3	.03
Receiving & Giving Help				
1. One of the good things about having your family help you is that you get the chance to help them back.	73.5	78.7	70.0	.05
Family Care of Sick Elderly				
1. Older people should not expect much help from their grandchildren.	68.5	43.4	30.0	.00
2. Once adult children have families of their own they should not be expected to do household tasks for their parents.	57.5	46.9	32.8	.00
3. If there were enough government or private programs to help older people with services like transportation and home-delivered meals, they could get everything they need without asking their children.	68.9	46.0	27.2	.00
4. It is better for a working woman to pay someone to take care of her elderly mother than to leave her job to take care of her herself.	72.6	77.0	54.3	.00
5. Most people get upset when they see an older person who is paralyzed from a stroke.	76.7	71.6	51.4	.00
6. I think of old age as a depressing time of life.	58.9	50.5	38.5	.04
Attitudes of Three Generations on Family support and care for elderly.				
Personal Control				
1. Many times I feel that I have little influence over the things that happen	42.5	31.8	58.6	.00
People's misfortunes result mostly from the mistakes they make.	48.0	32.8	48.6	.01

*Significance levels based on analysis of variance.

On the one item related to giving and receiving help, parents strongly endorsed the value of reciprocity. The majority (79 percent) of the middle generation agreed with the statement that one of the good things about having your family help you is that you get the chance to help them back. Grandparents and grandchildren also agreed with this statement, though less strongly.

Items related to family care of sick elderly consistently revealed a tendency for grandchildren to expect more of themselves and other family members than did parents and grandparents. This finding is similar to results reported by Campbell and Brody (1985) in their comparison of three generations of Japanese and Americans. This study differs from theirs as our sample included men and women and they surveyed only women. Still, it is striking that in all three cultures, grandchildren are more likely than both grandparents and parents to disagree with the statement that older people should not expect much help from grandchildren. In our sample, only 30 percent of grandchildren agreed with this statement, compared to 69 percent of grandparents and 43 percent of parents. Similarly, grandchildren tend to disagree with the view that adult children with families should not be expected to do household tasks for their parents. Only 33 percent of grandchildren agreed with this statement, compared to the majority (58 percent) of grandparents. Grandchildren are quite unlikely to agree that formal services could provide everything older people need. Only 27 percent of grandchildren agreed with this view, compared to a majority (69 percent) of grandparents. A majority of all three generations agreed that it is better for a working woman to pay someone to take care of her elderly mother than to leave her job to provide care. But grandchildren were the least likely to endorse this view. Only 51 percent of grandchildren agreed, compared to 73 percent of grandparents and 77 percent of parents.

Grandchildren tended to view old age more favorably than parents and grandparents. They were less likely than parents and grandparents to believe that most people find a paralyzed person distressing. About 51 percent of grandchildren agreed with this view, compared to 72 percent of parents and 77 percent of grandparents. A minority of grandchildren (39 percent) agreed that old age is a depressing time of life, compared to about half of parents (51 percent) and a majority of grandparents (59 percent).

The generations also differed on two questions related to personal control. The majority of grandchildren (59 percent) agreed that they feel they had little influence over the things that happen. This compared to a minority of grandparents (43 percent) and an even smaller proportion of parents (32 percent). Yet both grandchildren and grandparents were more inclined than parents to believe that people's misfortunes result mostly from the mistakes they make. Nearly half of the grandchildren (49 percent) agreed with this view, as did 48 percent of grandparents. But a minority (33 percent) of parents agreed. Evidently, the middle generation is most likely to feel that they can influence events, and least likely to attribute misfortune to personal mistakes. This may reflect different attributional styles which result from various degrees of involvement in events outside of the family. Parents' greater involvement may lead to increased awareness of the large number of events beyond personal control which can produce misfortunes.

Discussion

Consistent in these findings is the tendency of older family members, both parents and grandparents, to underestimate grandchildren's willingness and capacity to provide help. Grandchildren consider themselves a likely source of assistance to elderly, while grandparents and parents do not. This finding has been observed in three diverse cultures, and may reflect a near-universal definition of childhood as a time for education, play, and related activities, but not for elder care. If families cling to this definition in times of sickness, grandchildren may find themselves excluded from a primary family activity. Further, adults may deprive themselves of an important source of assistance. The grandchildren we interviewed were in their adolescence and certainly have the capacity to contribute to caregiving efforts.

Professional and community leaders may counteract this view by encouraging grandchildren to be involved in caregiving efforts.

Findings of our attitudinal survey also reveal grandchildren's positive views regarding family care and old age. In fact, grandchildren were more likely than older generations to endorse the "traditional" view that families should assume responsibility for elder care. They were also less likely to view old age as depressing and upsetting. We might view these generational differences as developmental changes, suggesting that, as people gain greater experience with old age and life in general, their views change in the directions observed. In other words, they become "jaded." Or they may reflect historical changes in expectations of old age. Regardless, they testify to the strong generational bond between these grandchildren and their grandparents. In the future we may look to grandchildren as a source of optimism and commitment to family care of the elderly.

References

Banister, J. (1984). An analysis of recent data on the population of China. *Population and development review, 10,* 241-271.

Brody, E.M. , Johnsen, P.T., Fulcomer, M.C., & Lang, A.M. (1983). Women's changing roles and help to aging parents: Attitudes of three generations of women. *Journal of gerontology, 38,* 597-607.

Campbell, R. & Brody, E. (1985). Women's changing roles and help to the elderly: Attitudes of women in the United States and Japan. *The Gerontologist, 25,* 584-592.

Davis-Friedmann, D. (1983). *Long lives: Chinese elderly and the communist revolution.* Cambridge, Mass: Harvard University Press.

Goldstein, A. & Goldstein, S. (1984). The challenge of an aging population in the People's Republic of China. Paper presented at the Annual Meeting of the Population Association of America, Minneapolis, Minnesota.

Liang, J. (1985) Aging in the People's Republic of China. In Sheppard, H. (Ed.) *Chinese perspectives on aging in the People's Republic of China.* Tampa, FL: International Exchange Center on Gerontology.

U.S. Bureau of the Census (1983). *1980 Census of population, Vol. 1, chapter B, United States summary.* Washington, D.C.: U.S. Government Printing Office.

Whyte, M.K. & Parish, W.L. (1984). *Urban life in contemporary China. Chicago:* The University of Chicago Press.

Zhu, C. (1985). The reform of China's social security system for the elderly. In Sheppard, H. (Ed.) *Chinese perspectives on aging in the People's Republic of China.* Tampa, FL: Internaitonal Exchange Center on Gerontology.

CHAPTER 7

FAMILY STRUCTURE AND ELDERLY PROBLEMS IN TAIWAN

Ramsay Leung-hay Shu[*]

Introduction

In view of the phenomenal developments taking place in Taiwan during the past forty years, one significant event of present concern is that the population is aging rapidly. People 65 years or older now comprise five percent of the total population, and will continue to increase steadily. In order to provide for the needs of the elderly population, it is essential to collect accurate and representative baseline data on this group. Most important in this undertaking would be information pertaining to their family structure, since the family has long been considered the foundation of Chinese society, and is intricately interwoven with all other social institutions.

Taiwan is however, marching towards the ranks of fully industrialized societies and its social institutions, particularly the family, are changing rapidly. Whereas the extended kinship system was idealized for thousands of years, the nuclear family is now dominant in reality. From the elderly's perspective, such changes inevitably would have momentous impact on their overall welfare. But the question is, how precisely are their families changing? What factors cause the most changes? And how do changes in their family structures influence their psychological adaptation, health conditions, coping mechanisms for life crisis situations, their economic well-being, and so forth? These questions need to be answered on the basis of empirical data. Thus, based on a representative sample survey of the elderly in the Taipei area, the present study investigates the significance of the elderly's family structure relative to their health, social and economic conditions. The results indicate that family structure is extremely important to the elderly's welfare, especially in terms of their relationships with family members. On the basis of these findings, some policy relevant recommendations are offered.

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For many centuries, the family has always been the fundamental basis of social solidarity in Chinese society. This point is confirmed by scholars and laymen alike. What is problematic is the precise nature of the Chinese family. In Taiwan, after four decades of economic development, progress in medicine, widespread promulgations of public health facilities and family planning programs, the life expectancy of the general population has been extended significantly, and people over 65 now amount to about five percent of the total population. It has been projected that by the year 2000, one-tenth of the population will be elderly (i.e., over 65).

Traditional Chinese society gave high respect to the aged. They enjoyed high social status as well as control of family properties. Thus, elderly people could depend on normative sanctions and material resources to survive their later years. The children, on the other hand, are bound by 'filial piety' values to provide care to their parents. As Taiwan becomes a newly industrialized society, however, massive changes have occurred in its various institutions: the economy has changed from an agricultural to an industrial mode of production; people have forsaken the villages and opt to live in the cities; and widespread education has instilled modern ideas into the new generation. In terms of the family, the traditional "grand family" system has also been replaced by either the "nuclear family" or the "stem family" models. In this context, it is obvious that the fate of the elderly in Taiwan is subject to critical examination. Both normatively and materially speaking, what the elderly could hitherto take for granted for their security throughout their later years has now been greatly eroded, and many are left to survive on their own. As more people become old, their needs will also increase correspondingly, and "elderly problems" will become more evident.

At this point, it should be clarified that "elderly problems" as used in this report are not such things as robbery, drug addiction, gambling or, in general, those problems that constitute perceived or real threats to the welfare of the society and its individual members. Rather, like that of orphans, the poor, or the handicapped, the plight of older persons is considered unacceptable in terms of prevailing humanitarian standards or traditionally valued norms, so much so that societal resources are called upon for their relief, and/or specific laws or programs are enacted for their benefit. In the present case, since social institutions (especially the family) in Taiwan have manifested drastic changes -- traditional caretaking functions for the elderly have become incompatible with existing social reality, while the new ones such as retirement benefits or social security programs have not been institutionalized -- the resulting outcome is a general misfit of the society's institutions with the elderly's needs. Even though the Old People Benefits Law has been implemented in Taiwan since 1980, its scope of coverage is considered inadequate; e.g., by defining the elderly population as aged 70 or above and, thus, withholding benefits from those in the 65-69 age group. On the other hand, the needs of the elderly are increasing rapidly due to their fast growing numbers. It is in this sense that the conditions of the elderly are manifestly perceived as problematic, and people from different spheres of life call upon the society, in general, and the government, in particular, to help solve their problems.

From the sociological standpoint (Rubington & Weinberg, 1975), a "social problem" can be analyzed as follows: Some concerned scholars or policy makers perceive that certain social phenomena, or conditions pertaining to particular groups of people in society, are so problematic that they would threaten the welfare of the general public and, thus, call for collective and/or additional mobilization of resources to deal with the given problematic phenomena. Some conditions constituting social problems may be rather universally accepted; e.g., issues of law and order, epidemics, war or civil unrest, etc. However, many other problematic phenomena may vary from group to group, or even from country to country (and across time), depending on sociocultural environments, political conditions, or even historical legacies. Thus, in the United States, the Johnson administration declared "War on Poverty" in the sixties, precisely in the midst of affluence, because it was felt that America could no longer tolerate the continued existence of poverty among its underprivileged members. Likewise, the United States was probably the first country to take affirmative action against discrimination, because it was perceived by many Americans that discrimination (be it against color, creed, or nationality) is inherently contradictory to the spirit of the U.S. Constitution. From this standpoint, the elderly in Taiwan have come to be perceived as a problem, not because they are culprits, but because they are seen as the victims of massive social changes that have occurred during the past several decades.

In Chinese society, the ideas of respecting the elderly and providing for their welfare have been so deeply ingrained in the collective mind that when issues were presented on their behalf; e.g., lack of provisions for their health care, income maintenance, housing, growing disrespect for the old, loneliness, and so forth, a legitimate social problem was recognized society-wide. Once a social phenomenon comes to be defined as a social problem, the stage is set for analyzing the given problem, including its antecedent conditions and consequences, as well as any implications it may have for other social structures.

Sociologists (as social scientists) emphasize the collection of empirical data on the given problem domain, analyze their characteristics vis-a-vis sociological theories, and provide empirically grounded conclusions. Finally, research findings are stated in terms of policy relevant recommendations or programs to be implemented such that the given social problem could be solved. Such recommendations or programs may not always be feasible, but the important point is that they are arrived at empirically.

Objectives

Following this perspective, the objectives of the present investigation are to collect empirical baseline data for scientific, systematic inquiry into the elderly's problems; analyze the salient relationships among various factors (especially in terms of the elderly's family structure); and ultimately provide concrete recommendations for improving the welfare of the elderly. We are interested in investigating the impact of "family structure" on the welfare of the elderly, including such dimensions as their physical and mental health, socioeconomic condition, and leisure activities. That family structure is chosen as the focus for this study is primarily because of its impact on the daily life of the elderly, especially in the context of the society in Taiwan. This impact can be observed in the overall significance of the family in Chinese society, in general. But, in addition, it is also due to the relative absence of government provisions (e.g., health care, housing, pensions, and other institutionalized programs) for the elderly, thus, in effect, mandating the family to continue assuming its traditional responsibilities despite the quantum jump from an agrarian society to a newly industrialized one.

Studies have indicated (Lai & Chen, 1981; Shu & Lin, 1984, 1988; Wang & Chen, 1987) that the nuclear family amounts to about 60% of all families in Taiwan, the stem (or three-generation) families constitute another 30%, and the remaining 10% are variously represented by other family types (including the traditionally exalted extended family). Thus, for the purpose of empirical investigation, it is tactically sound to focus on the distinction between the nuclear and the stem family. In other words, we believe that although the extended family has always been prescribed as the model family for Chinese society, in reality it is practically non-existent and, therefore, one should focus on the nuclear vs stem family distinction insofar as the elderly's conditions are concerned.

Those elderly living in the context of the nuclear family, of course, are less able to enjoy their later years (especially if they value the presence of the grandchildren). On the other hand, a three-generation family by definition has more members present, and would have more occasions for family conflicts (in Chinese society, such conflicts are often found among the elderly and the daughter-in-law). The elderly, could thus, be expected to subscribe to traditional views concerning family living arrangements, especially in terms of filial piety on the part of the children. However, as the children establish careers and families of their own, they are often torn between fulfilling their filial obligations and achieving "success" in extrafamilial domains. This dilemma is manifest even to the elderly people. Thus, the empirical question is to investigate how, given such conditions, the elderly would perceive and evaluate their family arrangements.

It would be appropriate here to elaborate on the term "family structure" as used in the present study. This term is used to indicate various types of family living arrangements found in given households, and is often used interchangeably with "household composition" in the family literature, especially by demographers. (A more detailed discussion on the concept of "family structure" can be found in Shu & Lin, 1988.) Some concrete types of family structure are stem family, nuclear family, three-generation family, single parent family, and so forth. To forestall possible confusion, it is useful to bear in mind the following points when examining family structure:

First, by definition, different family structures would involve correspondingly different structural arrangements of the relationships that are found among family members. Thus, to begin with, within the one-generation family, an elderly person living alone has no other member to relate to in his/her household, whereas one who lives with his/her spouse can always relate to another person in the household. In the context of the elderly's situation, this difference may be crucial in relieving the elderly of problems such as loneliness, mutual support (especially when sick), activities of daily living, etc. For two-generation families, the elderly live with their married or unmarried child(ren), and/or spouse, daughter-in-law, etc. Clearly, in this case, structural arrangements of the possible relationships could increase multifold. The elderly living in such a family could enjoy the emotional and material benefits of these additional relationships, but they may also suffer from complications that could arise from having additional people living under the same roof. In Chinese society, the norm of filial piety constrains the children (even after married) to obey their parents' wishes, to provide for them, and to take care of them in case of need. But should those in the second generation fail to live up to their obligations (for their own reasons), then the elderly may suffer from emotional costs, e.g., the subjective trauma of having children who have failed their expectations, loss of "face", and recurrent domestic conflicts. In a three-generation family, the structure becomes even more complicated with the addition of the grandchildren. Typically, the youngsters could enrich the elderly's life by bringing joy and attention to the family, but the elderly are often asked (or by default) to assume childcare responsibilities. Thus, it is clear that different family structures would involve different consequences for the elderly. The question is to empirically investigate what these consequences are, and to assess their costs and benefits.

Secondly, family structure is not to be confounded with family size, even though empirically the two concepts are often indistinguishable. Thus, an elderly person living alone means a family size of one, and an elderly person living with his/her spouse indicates a family size of two. But the family size of a two-generation family could range from two to ten-plus, depending on the number of children present; for a three-generation family, the family size becomes even more variable with the additional consideration of the grandchildren. The point is, it is the quality, rather than quantity, of the relationship present that is considered important here.

Thirdly, it is important to stress again that different family structures would impose different constraints on the family members, which is why "family structure" rather than "household composition" is used here. It is hoped that the above discussion has served to highlight the structural differences among one-, two-, and three-generation families, and their respective constraints. But if the significance of the structural constraints is not salient in the context of the elderly, let us cite the case of the single parent family vis-a-vis the typical nuclear family. Put simply, to maintain a family, there are certain tasks that have to be performed. Such tasks include earning a living, doing household chores, and (if children are present) caring for the children. In a nuclear family, there are two parents who can divide the labor and share the responsibilities but, in a single parent family, the sole head of household has to meet the responsibilities on his/her own. Given the fact that each person has precisely 24 hours a day, it is understandable that the single parent always has to prioritize his tasks and concentrate on fulfilling the more important ones (Shu, 1987; Weiss, 1979). Thus, different family structures involve qualitatively different constraints on family members.

Moreover, not only does family structure impose constraints on the incumbents within the sphere of family living, but it entails consequences in extra-familial activities as well. In terms of health care, if and when the elderly job sick, especially if it is chronic (e.g., Alzheimer's disease), the presence of family support could impact on their recovery patterns. Psychologically, older people often face life crisis events such as retirement, loss of spouse, and sickness. Again, emotional support from family members could contribute to successful coping outcomes in such events. Moreover, since the elderly are no longer economically productive, and retirement pensions are hardly institutionalized in Taiwan, children's provisions thus become all the more important to their material welfare. Even in the sphere of leisure, family arrangements could constrain their available options; those living in three-generation families by necessity would devote more of their time and energy to childcare, while others would be free to pursue their individual interests. In short, we can see that family structure not only has a direct impact on the welfare of the elderly, but also contributes to their well-being in other ways as well.

According to Maddox and Campbell (1985), one of the theories in the field of aging that has received the most attention in recent years is modernization theory. The proposition that the status of the elderly varies according to macro-social structural conditions (i.e. modernization) was first cogently stated by Cowgill and Holmes (1972). More recently, Cowgill (1986: 188) reaffirmed that "Modernization theory as applied to aging asserts that there are systematic relations between the extent of modernization of a society and the status and condition of the elderly." While the theory as originally stated has not been universally accepted by the social science community, it nonetheless provides a useful theoretical basis for the present investigation. That is, insofar as Taiwanese society has become newly industrialized, it is of heuristic interest to examine the family structure of the elderly from the modernization viewpoint. In concrete terms, we are interested in the urban/rural distinction in the case of Taiwan.

Studies on the conditions of the elderly in Taiwan have mushroomed in recent years and they have underscored the point for perceiving the elderly as a social problem and, thus, calling for systematic empirical investigation of their conditions, as well as better provision of services for this group. In particular, Chen and Chen (1982) emphasized the importance of the stem family for the elderly's welfare, but Kiang and Chang (1985) found that family structure did not have a significant impact on the elderly. Clearly, such discrepancies call for further examination of the given problem. The present investigation, by providing results based on a representative sample of the elderly in Taipei area, hopes to help clarify the issues that are involved.

Methods

The present study is a component of a multidisciplinary project, funded by the National Science Council (Taiwan), that together constitutes the most comprehensive study of the condition of the elderly in the Taipei area. Included in this team of researchers are psychologists, economists, sociologists, physicians, as well as those in public health. Unlike other large scale research projects funded by the National Science Council in recent years, the Taipei Study on Gerontology team decided to adopt a unified approach; i.e., even though each individual principal investigator is responsible for his own project, the team as a whole adopted a single sampling design and questionnaire. This approach would enable the team to obtain a larger and more representative sample, as well as comprehensive data on the conditions of the elderly, otherwise impossible if each investigator were to conduct his study individually. And each investigator could choose to focus his inquiry in depth, as well as relating his research problem to other fields.

The population from which the present sample was drawn consisted of those aged 65 or over and residing in the Taipei area (Taipei City and Taipei County), but excluding those housed in institutional settings. As of year-end 1986, there were 248,545 elderly in this population. A two-stage systematic sampling design was adopted, resulting in 3,042 cases. First, on the basis of the classificatory system of the Directorate-General of Budget, Accounting, and Statistics (DGBAS), all the districts ('li') in the Taipei area were grouped into three categories in terms of the urban/rural distinction:(1) highly urbanized, (2) of medium urbanization, and (3) of low urbanization. Of a total 1,421 districts in the Taipei area, this procedure resulted in 1,162 districts in the Type 1 urban area, 127 districts in Type 2, and 132 districts in Type 3. Since the latter two types are underrepresented in the Taipei area, they were deliberately oversampled. Upon stratification, there were 25, 13, and 13 districts randomly sampled within each category, respectively.

Subsequently, a systematic sampling method was adopted such that, within each given district, half of the elderly population would be chosen. The sampling frame for each district was obtained by sending research assistants directly to the respective household registration offices and compiling roster information on site. Specifically, if a certain household has one elderly person only, then that person would by design be selected into the sample. But if the household has more than one elderly person, then the target person would be randomly chosen. Altogether, 2,032, 507, and 503 elderly persons were chosen from the three categories, respectively, resulting in a total sample of 3,042 cases. Subsequently, interviewers were trained and sent out to the field throughout the Taipei area. However, on account of errors arising from inaccuracies in the roster, the failure to contact those respondents who had moved away, as well as some elderly who refused cooperation, etc., only 1,533 completed interviews were obtained. The actual response rate was thus 50.4%.

Results

The following presentation of results is based on the 1,533 completed interviews. First of all, Table 1 shows the frequency distribution of various family types. It can be seen that, for the present sample, the stem family (which is a family composed of three generational members, i.e., the respondent, his son and/or daughter-in-law, and at least one grandchild) is by far the most prevalent type, amounting to 43.7% of all the cases. Moreover, if the extended family is also added to the stem family, together they would constitute 49.4% of the entire sample. In other words, almost half of the sampled elderly lived together with their children as well as grandchildren, under the same roof. In contrast, only 8.8% of the elderly respondents lived by themselves; and another 11.5% lived with their spouse only. Such one-generational families constitute only 20.3% of this sample. On the other hand, those elderly couples living with their married sons and daughters-in-law amount to 7.1% of the cases, while the nuclear family (made up of the elderly couple living with their unmarried children) represent 10.5% of the sample. The single parent family; i.e., those nuclear families without the spouse of the respondent present, amount to another 5.1%. In the above three types, it can be seen that the elderly were all living with their children, married or unmarried. If, for the sake of convenience, the other family types are also aggregated with these three types, one may say that the two-generational families together constitute about 30.3% of all the cases. In short, the three-, two-, and one-generational families amount to about 50%, 30%, and 20% of the sample respectively.

Table 1
Distribution of Original Family Types

Family Type	
Living Alone	8.6%
2-Generation Family	7.2
3-Generation Family	43.7
Nuclear Family	11.2
Single-Parent Family	5.3
With Spouse Only	10.6
Extended Family	5.7
Others	7.7
	100.0

Table 1A
Elderly's Family Types

Family Type	
3-Generation Family	49.4 %
2-Generation Family	23.7
R & Spouse Only	10.5
Alone	8.4
Others	8.0
	100.0

The results shown in Table 1 are even more striking when they are compared to findings from other studies. To facilitate comparison, Table 2 has been structured like that in the classic study of Shanas et al. (1968: 187) of old people in three industrial societies. Overall, the results shown in Table 2 are the reverse of what Shanas and her colleagues reported. For instance, they (1968: 185-6) found that about a quarter of the aged population in Denmark, Britain, and the United States lived alone, and one-third of the elderly population in

Britain and slightly less than half in Denmark or the United States lived as married couples, without other members. In other words, no more than 27% of the elderly in Denmark, 45% in Britain, and 35% in the United States lived with their children. In contrast, 73% of the elderly in Taipei lived with their children. Furthermore, whereas 50% of the elderly in the present sample lived in three-generation households, only 5% in Denmark, 8% in the United States, and 13% in Britain, respectively, did so.

Table 2
Percentages of Unmarried and Married Elderly in Taipei Area by Household Composition

	Unmarried			Married		
	Men	Women	All	Men*	Women*	All*
1) Living alone	19.0	8.4	12.6	6.0	1.1	4.8
2) Living with spouse only	0.0	0.0	0.0	20.6	19.1	20.2
3) Living with married child (and others)**	52.5	71.3	63.8	45.7	63.4	49.9
4) Living with unmarried child (and others)	18.0	9.7	13.0	22.4	12.0	20.0
5) Living with others	10.5	10.6	10.6	5.3	4.4	5.1
Total	100.0	100.0	100.0	100.0	100.0	100.0
N =	295	442	737	603	183	786

*It is empirically possible for married elderly in Taipei to live alone; e.g., their spouse may be living with the children overseas.

**This is a priority code; i.e, households with married children may also include unmarried children, etc.

Compared to Western industrial societies, it is clear that the elderly in Taiwan can enjoy family life, by the presence of their children and grandchildren, much more fully than their counterparts elsewhere. Nor is the present finding a phenomenon peculiar to this study. By using secondary analysis of available government data over a ten-year period (and with sample sizes ranging from 9,442 in 1976 to 16,434 in 1985), Lo (1987) found that 78.3% of the elderly were living with their children in 1985; alternatively, 58.5% of the households were three-generation families. Incidentally, her study also indicated a steady decline in the proportion of the elderly living with their children during this period, i.e., from 83.7% in 1976 to 78.3% in 1985; similarly, three-generation families also declined from 67.4% to 58.5%.

Next to family structure, another critical variable for the present investigation is the elderly's place of residence; presently, this is taken as a proxy for the urban/rural distinction. If Cowgill and Holmes's modernization hypothesis (1972) is valid, then we would expect that family structure would be manifestly different in the city as compared to rural areas. Strangely enough, as shown in Table 3, there is no significant relationship between these two variables (chi square results significant at 0.36 level). Lest this may be an incidental phenomenon, we also found that urban/rural residence has no manifest relationships with the elderly's sex status (chi square significant at 0.09 level), their work status (chi square at 0.96 level), total number of children living with them (chi square at 0.58), particular types of living arrangements (chi square at 0.45), whether they were satisfied with their present living arrangements (chi square at 0.0), and whether they hoped to change it (chi square at 0.76). We may conclude, insofar as the present study is concerned, that there is no significant relationship between family structure and urban/rural residence. However, it is to be noted that Taipei area is the most urbanized region in Taiwan, and even its rural areas may be more urbanized than some of the townships elsewhere in the island, just as it is the case for the rural areas in New York metropolitan region.

Table 3
Family Structure, by Rural-Urban Categories

	Taipei City	Taipei Hsien		
		Urban	Rural	Total
Family Type				
3-Generations	61.5	20.6	17.9	756
	48.3	52.2	50.2	49.4
2-Generations	68.0	16.5	15.4	363
	25.7	20.1	20.8	23.7
R & Spouse Only	61.3	19.4	19.4	160
	10.2	10.4	11.5	10.5
Alone	59.4	24.2	16.4	128
	7.9	10.4	7.8	8.4
All Others	61.8	17.1	21.1	123
	7.9	7.0	9.7	8.0
Column	962	299	269	1530
Total %	62.9	19.5	17.6	100.0

Chi Square = 8.34 with 8 degrees of freedom. Significance = .4007. Eta = 0.01 with Famtype dependent; = 0.05 with City dependent. Number of missing observations = 3.

Another factor that could have confounded the above relationship is the elderly's place of birth. Since it is well known that in 1949 there was a mass influx of mainlanders to Taiwan, who by now would mostly have reached old age and who are disproportionately concentrated in the Taipei area, it is important that any examination of the elderly's urban/rural residence take this into account. Thus, as shown in Table 4, there is a highly significant relationship between family structure and the elderly's place of birth (chi square is significant at less than the 0.001 level). Even upon controlling for the above urban/rural distinction, further examination of these two variables still manifests significant relationships, with chi square results all significant at beyond the 0.01 level. Thus, in the present case, it is not so much the elderly's place of residence that impacts on their family structure, but their place of birth.

Table 4
Family Structure, by Place of Birth

Family Type	Taipei Hsien	Taipei City	Taiwan, Other	Mainland	Total
3-Generations	53.4	9.2	21.7	15.7	738
	59.5	72.3	66.1	23.2	49.3
2-Generations	37.6	3.4	11.2	47.8	356
	20.2	12.8	16.5	34.1	23.8
R & Spouse Only	35.7	3.8	10.2	50.3	157
	8.5	6.4	6.6	15.8	10.5
Alone	21.3	1.6	7.9	69.3	127
	4.1	2.1	4.1	17.6	8.5
All Others	42.9	5.0	13.4	38.7	119
	7.7	6.4	6.6	9.2	7.9
Column	662	94	242	499	1497
Total %	44.2	6.3	16.2	33.3	100.0

Chi Square = 239.91 with 12 degrees of freedom. Significance = .0001. Eta = 0.30 with Famtype dependent; = 0.31 with V2 dependent. Number of missing observations = 36.

Demographically, it has been found that age and sex often affect the family living patterns of the elderly (Shanas et al, 1968). The present study also indicates that this is the case in Taiwan. Tables 5 and 6 show that family structure is highly related to both age and sex of the elderly, with chi square significant at less than the 0.001 level. It can be seen that the old-old (75 or older) are overrepresented in the three-generation families, whereas the young-old (65-74) are overrepresented among those living in two-generation families and those living with their spouse only. Females are more often found in three-generation families, while males are in the other family types. Thus it appears that as the elderly become progressively more aged, there are more female survivors relative to males, and they are more likely to be found in three-generation families. Furthermore, this relationship holds even by controlling by for sex when examining age, and vice versa.

Table 5
Family Structure by Age

Family Type	65-69	70-74	75-79	80-84	85+	Total
3-Generation	27.4	32.5	20.5	14.4	5.2	751
	42.5	49.0	53.8	61.4	55.7	49.6
2-Generation	43.4	33.9	14.0	7.0	1.7	357
	32.0	24.3	17.5	14.2	8.6	23.6
R & Spouse Only	35.0	38.1	16.9	7.5	2.5	160
	11.5	12.2	9.4	6.8	5.7	10.6
Alone	34.9	31.0	21.4	7.9	4.8	126
	9.1	7.8	9.4	5.7	8.6	8.3
Others	19.8	27.3	23.1	17.4	12.4	121
	4.9	6.6	9.8	11.9	21.4	8.0
Column	485	498	286	176	70	1515
Total %	32.0	32.9	18.9	11.6	4.6	100.0

Chi Square = 79.41 with 16 degrees of freedom. Significance = .0001. Eta = 0.57 with Famtype dependent; = 0.22 V1a dependent. Number of missing observations = 18.

Table 6
Family Structure, by Gender

Family Type	Male	Female	Total
3-Generation	47.8	52.2	756
	40.0	62.9	49.4
2-Generation	71.3	28.7	363
	28.7	16.6	23.7
R & Spouse only	78.1	21.9	160
	13.9	5.6	10.5
Alone	71.9	28.1	128
	10.2	5.7	8.4
Others	52.8	47.2	123
	7.2	9.2	8.0
Column	902	628	1530
Total %	59.0	41.0	100.0

Chi Square = 97.29 with 4 degrees of freedom. Significance = .0001. Eta = 0.13 with Famtype dependent; = 0.25 with Sex dependent. Number of missing observations = 3.

Similarly, as shown in Table 7, marital status is found to be significantly related (at the 0.001 level) to family structure. Note that the widowed are overrepresented in three-generation families. Again, the relationship is maintained even with sex controlled.

Table 7
Family Structue, by Marital Status

Family Type	Never Married	Married	Remarried	Widowed	Divorced, Other	Total
3-Generation	0.0	43.9	4.9	48.8	2.4	752
	0.0	42.0	48.7	64.3	34.6	49.4
2-Generation	0.0	60.3	9.1	27.0	3.6	363
	0.0	27.9	43.4	17.2	25.0	23.8
R & Spouse Only	0.0	100.0	0.0	0.0	0.0	157
	0.0	20.0	0.0	0.0	0.0	10.3
Alone	21.9	29.7	3.1	35.9	9.4	128
	73.7	4.8	5.3	8.1	23.1	8.4
All Others	8.1	34.1	1.6	48.8	7.3	123
	26.3	5.3	2.6	10.5	17.3	8.1
Column	38	786	76	571	52	1,523
Total %	2.5	51.6	5.0	37.5	3.4	100.0

Five out of 25 (20.0%) of the valid cells have expected cell frequencies less than 5.0; minimum expected cell frequency = 3.069.
Chi Square = 494.24 with 16 degrees of freedom. Significance = .0001. Eta = 0.31 with Famtype dependent; = 0.32 with V107 dependent. Number of missing observations = 10.

Not surprisingly, the elderly's family structure is also related to their prior marital experiences. Thus, we find that family structure is significantly related to their age at marriage (chi square significant at less than the 0.001 level). As shown in Tables 8 to 10, their particular conditions leading to marriage, extent of economic self sufficiency at the time, and whether or not they moved out to establish neolocal residence are all significantly related (at less than the 0.001 level) to their family structure. Thus, the elderly's early marital experiences clearly exercise sizeable and prolonged effects on their present family structure.

Table 8
Family Structure, by Conditions of Marriage

Family Type	Family Sponsor	Self-Choice	Live-In Daughter	Married-In Husband	Predetermined	Others	Total
3-Generation	62.2	14.0	14.8	2.8	5.6	0.7	752
	50.1	43.2	63.8	65.6	50.6	55.6	51.0
2-Generation	67.4	17.8	8.4	1.7	4.5	0.3	359
	25.9	26.3	17.2	18.8	19.3	11.1	24.3
R & Spouse Only	56.9	28.8	6.3	0.6	6.3	1.3	160
	9.7	18.9	5.7	3.1	12.0	22.2	10.8
Alone	73.2	12.4	5.2	1.0	8.2	0.0	97
	7.6	4.9	2.9	3.1	9.6	0.0	6.6
All Others	57.9	15.0	16.8	2.8	6.5	0.9	107
	6.6	6.6	10.3	9.4	8.4	11.1	7.3
Column	934	243	174	32	83	9	1475
Total %	63.3	16.5	11.8	2.2	5.6	0.6	100.0

Eight out of 30 (26.7%) of the valid cells have expected cell frequencies less than 5.0; minimum expected cell frequency = 0.592.
Chi Square = 51.62 with 20 degrees of freedom. Significance = .0001. Eta = 0.07 with Famtype dependent; = 0.07 with V109 dependent. Number of missing observations = 58.

Table 9
Family Structure, by Economic Situation at Marriage

Family Type	Self Sufficient	Moderate Support	Sizeable Support	Other	Total
3-Generation	58.8	22.7	16.5	2.0	741
	48.1	55.4	53.3	71.4	50.8
2-Generation	70.4	17.0	12.0	0.6	358
	27.8	20.1	18.8	9.5	24.6
R & Spouse Only	68.4	15.8	14.6	1.3	158
	11.9	8.3	10.0	9.5	10.8
Alone	49.5	22.1	26.3	2.1	95
	5.2	6.9	10.9	9.5	6.5
Others	59.3	25.9	14.8	0.0	108
	7.1	9.2	7.0	0.07.4	7.4
Column	907	303	229	21	1460
Total %	62.1	20.8	15.7	1.4	100.0

Three out of 20 (15.0%) of the valid cells have expected cell frequencies less than 5.0; minimum expected cell frequency = 1.366.

Chi Square = 31.79 with 12 degrees of freedom. Significance = .0015. Eta = .04 with Famtype dependent; = 0.13 with V110 dependent. Number of missing observations = 73.

Table 10
Family Structure, By Residence with Family After Marriage

	Moved Out	Stayed	Lived out Before	Invol.	Others	Total
Family Type						
3-Generation	30.1	56.4	11.0	1.7	0.7	753
	55.9	56.7	34.0	21.3	26.3	50.9
2-Generation	22.1	42.3	27.6	6.4	1.7	362
	19.7	20.4	41.0	37.7	31.6	24.5
R & Spouse Only	27.5	37.5	26.9	6.9	1.3	160
	10.8	8.0	17.6	18.0	10.5	10.8
Alone	34.4	42.7	8.3	11.5	3.1	96
	8.1	5.5	3.3	18.0	15.8	6.5
Others	20.2	65.1	9.2	2.8	2.8	109
	5.4	9.5	4.1	4.9	15.8	7.4
Column	406	750	244	61	19	1480
Total%	27.4	50.7	16.5	4.1	1.3	100.0

Six out of 25 (24.0%) of the valid cells have expected cell frequencies less than 5.0; minimum expected cell frequency = 1.232.
Chi Square = 127.32 with 16 degrees of freedom. Significance = 0.0000. Eta = 0.12 with Famtype dependent; = 0.19 with V111 dependent. Number of missing observations = 53.

Since family structure implies the presence of various types of relationships among household members, it is understandable that family structure is also highly related to the number of children (either son or daughter) ever born to the elderly, as well as number of children co-residing with them, both significant at the 0.000 level. This finding is also supported by demographic considerations, in the sense that the more children there are available, the more likely the elderly would maintain either three- or two-generation households. Conversely, the fewer the children, the less possible for the elderly to maintain multi-generation households, even if they wish. Furthermore, the eta coefficient for the number of sons living with the elderly is 0.57, compared to 0.15 for the daughters, indicating that the former is much more predictive of family structure than the latter.

Again, this supports the common sense notion that the Chinese elderly prefer to live with their sons rather than daughters. The same finding is manifest in Table 11, which shows that among those who lived with their children, there was a highly significant relationship between family structure and particular choices among the children (chi square significant at less than the 0.001 level). In particular, it can be observed that the elderly much prefer to live with sons rather than daughters, and that the oldest son is by far the favorite choice.

Table 11
Family Structure, By Offspring Status

	Sons				Daughters			
	Oldest	2nd	3nd	4th +	Oldest	Other	Others	Total
Family Type								
3-Generation	49.9	19.7	11.9	4.1	7.5	4.7	2.2	681
	69.8	67.0	65.9	50.9	45.1	50.8	62.5	63.9
2-Generation	36.8	18.3	11.3	7.5	15.1	9.0	2.0	345
	26.1	31.5	31.7	47.3	46.0	49.2	29.2	32.4
Others	51.3	7.7	7.7	2.6	25.6	0.0	5.1	39
	4.1	1.5	2.4	1.8	8.8	0.0	8.3	3.7
Column	487	200	123	55	113	63	24	1,065
Total %	45.7	18.8	11.5	5.2	10.6	5.9	2.3	100.0

Five out of 21 (23.8%) of the valid cells have expected cell frequencies less than 5.0; minimum expected cell frequency = 0.879.
Chi Square = 50.15 with 12 degrees of freedom. Significance = .0001. Eta = 0.15 with Famtype dependent; = 0.15 with V247 dependent. Number of missing observations = 468.

Attitudinally, the results also clearly indicate that there are significant relationships between the actual and preferred family living arrangements of the elderly. An Index of Three Generational Living was specially developed in the present study, consisting of 10 items. Table 12 shows the frequencies of individual items cross-tabulated by family structure. A one-way analysis of variance was performed on the combined index. Even though not all items are significantly related to family structure, the analysis of variance results indicate that family structure does impact on three-generation living attitudes, at less than the 0.001 level. Also, when asked specifically whether married children should live with their parents, the responses vary in terms of their family structure (chi square significant at less than the 0.001 level). Table 13 shows that those in three-generation families were most likely, and those living with their spouse least likely, to believe that married children should live with their parents. Incidentally, among the various reasons cited for living together, the most salient ones are to take care of each other, on account of filial piety, safety, and the elderly's dependence on their children.

Table 12
Attitudes Toward 3-Generation Living
(Percent Agreeing)

	3- Gens.	2-Gens.	R & Spouse Only	Living Alone	Other
Problems are more likely to develop between mothers-in law and daughters in 3-gen. families in same household.	25	45	55	54	32
It is less expensive for 3 generations to live together.	72	77	73	71	75
Older parents would like to live alone rather than unhappily with their children, because current young generation does not have as much filial piety as prior generations.	31	52	51	59	45
People today have their own income; you can do nothing if they want to move out and live on their own.	65	73	77	78	65
Young couples in nuclear families are less likely to get divorced.	69	59	65	61	66
One is less likely to have problems with children living in 3 gen. families, or under the care of grandparents.	82	80	75	78	80
Father-in-law and mother-in-law should help in some housework, if daughter-in law has a job outside.	88	85	88	86	87
The main reason a married son wants to move out is for his job.	73	73	82	70	73
Many people expect 3-gens. to live together, but frequently younger generations have to move out because of space problems.	70	71	77	68	67
If there are enough financial resources, the best living arrangement is for elderly parents and thier children to live separately in houses close to each other.	58	70	74	63	59

Table 13
"Should Children Live with Parents" by Family Structure

Family Type	Yes	No Need To	Other	Total
3-Generation	66.0	17.9	16.2	755
	56.0	36.2	46.4	49.5
2-Generation	51.7	29.3	19.1	362
	21.0	28.4	26.2	23.7
R & Spouse Only	36.9	45.0	18.1	160
	6.6	19.3	11.0	10.5
Solitaire	52.0	29.6	18.4	125
	7.3	9.9	8.7	8.2
Others	65.0	18.7	16.3	123
	9.0	6.2	7.6	8.1
Column	889	373	263	1525
Total %	58.3	24.5	17.2	100.0

Chi Square = 73.61 with 8 degrees of freedom. Significance = .0001. Eta = 0.09 with Famtype dependent; = 0.14 with V270 dependent. Number of missing observations = 8.

Similarly, the elderly's willingness to live with their married children also corresponds closely to their actual living arrangement, with chi square significant at less than the 0.001 level. Moreover, it can be observed from Table 14 that those living in three-generation households are most willing (90%), while those living alone are least willing (58%), to live with their married children. The most often cited reasons to account for their willingness are the ability to take care of each other, emotional support by the children, and traditional norms.

Table 14
"Are You Willing to Live with Your Married Children," by Family Structure

Family type	Yes	No	Others	Total
3-Generation	90.6	5.1	4.4	752
	57.0	18.3	28.7	49.5
2-Generation	72.5	17.6	9.9	363
	22.0	30.8	31.1	23.9
R & Spouse Only	59.5	33.5	7.0	158
	7.9	25.5	9.6	10.4
Alone	58.1	25.8	16.1	124
	6.0	15.4	17.4	8.2
Others	70.2	17.4	12.4	121
	7.1	10.1	13.0	8.0
Column	1,195	208	115	1518
Total %	78.7	13.7	7.6	100.0

Chi Square = 163.90 with 8 degrees of freedom. Significance = .0001. Eta = 0.25 with Famtype dependent; = 0.26 with V272 dependent. Number of missing observations = 15.

Even more to the point, there is a highly significant relationship between their actual living arrangement and satisfaction with it. Table 15 shows that this relationship is significant at less than the 0.001 level; again, those in three-generation households are most satisfied (79%), whereas those living alone, least satisfied (53%) with their present living arrangements. The reasons most often mentioned are being able to live comfortably, traditional norms, having their daily activities taken care of, as well as children's filial piety.

Table 15
Satisfaction with Living Arrangements, by Family Structure

Family Type	Satisified	No opinion	Not Satisfied	Total
3-Generation	79.4	17.6	3.0	756
	53.2	46.0	20.7	49.5
2-Generation	70.5	19.3	10.2	363
	22.7	24.2	33.3	23.8
R & Spouse Only	73.0	19.5	7.5	159
	10.3	10.7	10.8	10.4
Alone	52.8	23.6	23.6	127
	5.9	10.4	27.0	8.3
Others	72.4	20.3	7.3	123
	7.9	8.7	8.1	8.0
Column	1,128	289	111	1,528
Total %	73.8	18.9	7.3	100.0

Chi Square = 83.37 with 8 degrees of freedom. Significance = .0001. Eta = 0.15 with Famtype dependent; = 0.22 with V274 dependent. Number of missing observations = 5.

Finally, the elderly's expressed intent to change their living arrangements is also consistently related to their present condition. As shown in Table 16, this relationship is significant at less than the 0.001 level; those in three-generation households were the least intent (6%), and those living alone the most intent (22%) to change their living arrangements.

Table 16
Elderly's Intention to Change Current Living Arrangements, by Family Structure

Family Type	Yes	Doesn't Matter	No	Total
3-Generation	5.7	16.2	78.0	751
	29.1	45.9	53.1	49.5
2-Generation	11.7	18.6	69.7	360
	28.4	25.2	22.8	23.7
R & Spouse Only	11.4	15.8	72.8	158
	12.2	9.4	10.4	10.4
Alone	23.2	24.0	52.8	125
	19.6	11.3	6.0	8.2
Others	13.0	17.9	69.1	123
	10.8	8.3	7.7	8.1
Column	148	266	1,103	1,517
Total %	9.8	17.5	72.7	100.0

Chi Square = 53.38 with 8 degrees of freedom. Significance = .00001. Eta = 0.15 with Famtype dependent; 0.18 with V277 dependent. Number of missing observations = 10.

Thus, the results consistently show that the elderly's family structure is closely related to prior family experiences. It is significantly related to their age at marriage and conditions leading to it, number of children ever born as well as those residing with them presently, and their self-perceived and preferred family living arrangements. The elderly's lifetime experiences tend to validate their mode of family living presently, and influence their extent of satisfaction with it accordingly.

Another dimension often considered critical to the well-being of the elderly is the extent of their participation in socially legitimized roles. Social disengagement theory (Cumming & Henry, 1962) posits that as the elderly withdraw from their formerly active roles, especially those in the work force, they are socially defined as "useless" and left to wither away during their final years. If this is the case, the elderly's family structure should impact on their particular social relationships through their status as elderly, as well as their participation in such roles. Since different family structures predicate the presence or absence of various family members, such as the elderly's spouse, children, or grandchildren in each given household, it is not surprising that the results indicate that family structure is significantly related (chi square significant at less than the 0.001 level) to the elderly's extent of involvement with their children, grandchildren, relatives, parents, spouse, household chores, and even civic participation -- but not in terms of friends, neighbors, religious activities, participation in social groups, or personally interested activities.[1]

Moreover, the elderly's subjective assessment of their participation in such social roles apparently coincides with their actual family structural arrangements. That is, in terms of their extent of satisfaction with various roles, family structure is found to be significantly related (chi square at less than the 0.001 level) to their respective situations with their children, grandchildren, relatives, parents, and spouse, but not with friends, neighbors, or participation in household work, civic religious, social and personal activities. Finally, by combining individual elderly persons satisfaction scores on these twelve items, it is possible to create an index of Social Role Satisfaction. A one-way analysis of variance (not shown) indicates that family structure exercises a significant impact on the extent of the elderly's satisfaction with their social roles, at less than the .001 level.

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[1] One-way analysis of variance results of the effect of family structure on numbers of hours spent in above mentioned roles generally tend to corroborate the chi square findings, even though the applicable number of cases tends to be greatly reduced. Specifically, at the 0.01 level, family structure is significally related to number of hours contact with children, grandchildren, relatives, spouse, and in civic activities, but not significant in terms of friends, activiites.

The point is, those elderly in three-generation households generally tend to be significantly more satisfied with their familial relationships (i.e., with their children, grandchildren, spouse, relatives, and so forth) than those in other family types, but there are no manifest significant differences in participation in extra-familial roles (e.g., with neighbors or friends, and in civic, religious, social or personal activities). One could interpret the above findings as indicating that Chinese elderly are not interested in participating in extra-familial activities, anyway. However, to the extent that family life is important to the elderly's welfare, then it is clear that specific types of family structure do exercise differential impacts on their well-being. In particular, the three-generation model does appear to allow the elderly to live their lives with much greater satisfaction.

In terms of socioeconomic characteristics, the elderly's family structure also tends to be closely related to their religious beliefs, educational attainment, lifetime job, present work status, headship of the household, and ownership and size of their housing, all manifesting significant relationships at 0.000 levels. Thus, Table 17 shows that, for instance, those elderly who believed in Buddhism or held folk beliefs were overrepresented in three-generation families, whereas those who ere Christians or had no religious beliefs at all were more likely to live with their spouse only, or by themselves.

Table 17
Religious Belief, by Family Structure

Family Type	Budlhism	Christianity	Folk Beliefs	None	Tao & Others	Total
3-Generations	45.1	3.7	31.3	17.9	2.0	756
	57.4	30.4	56.0	35.5	36.6	49.4
2-Generations	37.5	5.2	22.9	30.9	3.6	363
	22.9	20.7	19.6	29.5	31.7	23.7
R & Spouse Only	30.0	11.9	24.4	29.4	4.4	160
	8.1	20.7	9.2	12.4	17.1	10.5
Alone	23.4	11.7	21.9	39.8	3.1	128
	5.1	16.3	6.6	13.4	9.8	8.4
Others	31.7	8.9	29.3	28.5	1.6	123
	6.6	12.0	8.5	9.2	4.9	8.0
Column	594	92	423	380	41	1,530
Total %	38.8	6.0	27.6	24.8	2.7	100.0

Three out of 25 (12.0%) of the valid cells have expected cell frequencies less than 5.0; minimum expected cell frequency = 3.296.
Chi Square = 92.89 with 16 degrees of freedom. Significance = .0001. Eta = 0.19 with Famtype dependent; = 0.13 with V5 dependent. Number of missing observations = 3.

In terms of educational attainment, from Table 18, it also appears that the greater the education of the elderly, the more likely they are to live with their spouse only, or by themselves; conversely, the less their education, the more likely they are to be found in three-generation families. Table 19 indicates that those elderly in three-generation families were less likely, while the others were more likely, to be working. In three-generation families, the children (either son or daughter) were more likely to be household heads, while the elderly were likely to be household heads in other family types. Similarly, housing for three-generation families was most likely to be owned by the children, whereas the elderly were more likely to own their houses in the other family types.

Table 18
Education of Respondent,
by Family Structure

		Primary		High School			College &	
Family Type	None	Some	Grad.	Jr.	Sr.	Technical	Beyond	Total
3-Generation	56.6	10.2	17.7	4.1	4.8	2.9	3.7	753
	58.0	44.5	56.4	32.0	35.6	30.1	24.8	49.3
2-Generation	37.5	14.0	12.4	11.0	9.1	7.7	8.3	363
	18.5	29.5	19.1	41.2	32.7	38.4	26.5	23.8
R & Spouse	31.9	9.4	16.9	3.8	9.4	8.1	20.6	160
Only	6.9	8.7	11.4	6.2	14.9	17.8	29.2	10.5
Alone	43.8	14.1	12.5	7.8	7.8	5.5	8.6	128
	7.6	10.4	6.8	10.3	9.9	9.6	9.7	8.4
Others	52.8	9.8	12.2	8.1	5.7	2.4	8.9	123
	8.9	6.9	6.4	10.3	6.9	4.1	9.7	8.1
Column	734	173	236	97	101	73	113	1,527
Total %	48.1	11.3	15.5	6.4	6.6	4.8	7.4	100.0

Chi Square = 141.27 with 24 degrees of freedom. Significance = .0001. Eta = 0.15 with Famtype dependent; = 0.25 with V3 dependent. Number of missing observations = 6.

Table 19
Current Employment Status,
by Family Structure

Family Type	Working	Not Working
3-Generation	13.2	86.8
	35.3	52.7
2-Generation	23.2	76.8
	29.7	22.3
R & Spouse Only	23.9	76.1
	13.4	9.7
Solitaire	28.9	71.1
	13.1	7.3
Others	19.5	80.5
	8.5	8.0
Column	283	1,245
Total %	18.5	81.5

Chi Square = 31.57 with 4 degrees of freedom. Significance = .0001. Eta = 0.10 with Famtype dependent. Number of missing observations = 5.

On the other hand, it is interesting to find no significant relationship between the elderly's family structure and their general health conditions. Specifically, there were no significant differences in terms of the number of self reported chronic diseases (chi square significant only at 0.10 level), in terms of their present self conscious health condition (0.50 level), or their health compared to five years ago (0.86 level). Moreover, in terms of their daily living activities; e.g., dressing grooming, taking a bath, etc., not only are individual chi square results on the eleven item scale nonsignificant, but one-way analysis of variance also indicates that family structure has no significant relationship with the elderly's abilities to perform daily activities.

However, there is a significant relationship between the support system of the elderly and their family structure. For instance, if they are concerned with health problems, the persons from whom they would seek help vary in terms of their family structure (chi square significant at <.001 level). As shown in Table 20, if the elderly person lives with his spouse, the latter would be his primary source of help; if he lives in two- or three-generation families, then he would more likely seek his children's support. If he lives alone, he probably has few immediate relatives and, therefore, would have to rely more on the support of friends, neighbors, or others. Family structure is also highly related to the Index of Family Support Function (not shown), with a one-way analysis of variance significant at the .002 level. Again, the results indicate that those elderly in three-generation families have the most support from their immediate relatives, followed respectively by those in two-generation families and, elderly living alone.

Table 20
"If Sick, to Whom Would you Go Most Often?",
by Family Structure

	Spouse	Son	Daughter	Daughter-in-law	Grand-Children	Relative	Friends	Others	N/A	Total
3-Generation	17.1	46.2	8.5	5.2	2.4	0.5	0.3	2.3	17.6	755
	34.0	67.1	50.8	76.5	54.5	14.3	8.3	32.7	46.3	50.3
2-Generation	38.9	28.9	11.2	0.8	1.1	1.7	0.8	2.0	14.6	357
	36.7	19.8	31.7	5.9	12.1	21.4	12.5	13.5	18.1	23.8
R & Spouse	56.7	15.3	1.3	1.3	1.3	0.6	1.3	2.5	19.7	157
Only	23.5	4.6	1.6	3.9	6.1	3.6	8.3	7.7	10.8	10.5
Alone	0.9	14.2	9.7	0.9	0.0	7.1	11.5	14.2	41.6	113
	0.3	3.1	8.7	2.0	0.0	28.6	54.2	30.8	16.4	7.5
Others	17.8	23.7	7.6	5.1	7.6	7.6	3.4	6.8	20.3	118
	5.5	5.4	7.1	11.8	27.3	32.1	16.7	15.4	8.4	7.9
Column	379	520	126	51	33	28	24	52	287	1500
Total %	25.3	34.7	8.4	3.4	2.2	1.9	1.6	3.5	19.1	100.0

Thirteen out of 45 (28.9%) of the valid cells have expected cell frequencies less than 5.0; minimum expected cell frequency = 1.808.
Chi Square = 466.44 with 32 degrees of freedom. Significance = .0001. Eta = 0.33 with Famtype dependent; = 0.19 with Help dependent. Number of missing observations = 33.

Conclusion

The present study has found that the elderly's family structure consistently impacts on their family life, especially in terms of their satisfaction with it. There are substantial differences in their relationships with family members and their socioeconomic characteristics, but family structure does not appear to exercise any appreciable impact on the elderly's extrafamilial roles, e.g., towards their friends, neighbors, social or religious activities, etc. To our surprise, we have also found no significant relationships between family structure and the elderly's urban/rural residence, their activities for daily living, or their general health conditions. However, to the extent that most of the elderly's lives are lived in their family context rather than in extrafamilial activities, we may conclude that family structure is indeed crucial to their conditions, in general, and relationships with individual family members, in particular. At this point, we may even surmise that those elderly living in three-generation families would be the happiest, while those living alone the unhappiest, with their lives.

Because of practical considerations, it is beyond the scope of the present investigation to examine in greater depths the causal relationships between family structure and elderly problems in general. We hope the present study has laid the groundwork by highlighting the salient characteristics of the elderly's problems vis-a-vis their family structure. The present report is not intended to provide conclusive statements; indeed, its purpose from the very beginning has been to establish empirical, baseline data regarding the significance of the elderly's family structure. It has also raised some interesting questions. It is hoped that the findings reported here have documented sufficiently clearly the extent of this significance. But more importantly, the results reported here only mark the beginning of our efforts, and signify that the elderly's family structure (especially since Taiwan is a newly industrialized society) indeed is a significant research problem. We hope that in the near future there will be more like-minded researchers joining hands with us in our endeavors to continue this line of investigation.

Recommendations

Despite phenomenal changes in Taiwan for four decades, the family institution remains strong and viable, especially for the sake of the elderly. It is clear that massive structural changes have occurred to the family, and most likely, in its internal dynamics as well; witness the rapidly growing numbers of divorces in recent years. However, the present study found that at least half of the elderly lived in three-generation families; i.e., with their children's generation and their grandchildren's generation, and another quarter of them lived with their children, married or otherwise. Just in this respect alone, the elderly in Taiwan are in a much more fortunate position than their counterparts in Western societies. If not adequately provided for financially, at least they could enjoy happy family living, and their attitudes appear to be highly consistent with their actual family living patterns. Therefore, we offer the following recommendations:

(1) that because the elderly are still by and large living with their children, it is all the more important that government take active measures to ensure the strong viability of the family institution despite continuing massive changes in other institutions.

(2) the above point is not liberal rhetoric. Indeed the point is, given the experience of social security programs developed in Western societies over the past fifty years, that the government has to provide for the welfare of the elderly, one way or another. If the government does not take measures to keep the family institution viable, then it will pay in terms of social security, welfare or other similar programs to sustain the broken families. Given the choice, we believe it would be both fiscally sound policy as well as in keeping with traditional values to promote three-or two-generation family living arrangements.

(3) positive programs that could be adopted, based on the above views, include tax incentives to encourage three- or two-generation living arrangements. That is, additional tax credits could be recognized if the taxpayer is living with as well as supporting his parents. Costs for health insurance for taxpayers' elderly parents could also be considered deductible items, in addition to those for taxpayers themselves.

(4) also, the private sector should be encouraged to build and run nursing homes for the elderly. From the standpoint of cost/benefit analysis, it would not be wise to continue expanding the present programs of building nursing homes for the elderly. Instead, monies should be provided to private, social welfare agencies such that they could eventually assume primary responsibilities for elderly care.

(5) on the other hand, the real needs of those elderly who are destitute, homeless, handicapped, and/or childless should also be recognized, and appropriate provisions for their needs should be implemented. Such people could be provided for through existing programs for the poor and the elderly, but entitlement standards should be reviewed carefully such that recipients do not merely subsist on aid, but live on more dignified living standards.

(6) despite above measures, it should also be recognized that, given the forces of social change external to the family institution, three- or two-generation family living arrangements will continue to decrease, and that more and more elderly will, instead, live with their spouse only, or by themselves. The above mentioned programs could only slow but not stop such a trend. Thus, both the government and the private sector should adopt more extensive retirement programs, and encourage more active participation among the employees.

References

Cumming, E. & Henry, W.E. (1961). *Growing old: The process of disengagement*. New York: Basic Books.

Cowgill, D.O. (1986). *Aging around the world*. Belmont, CA: Wadsworth.

Cowgill, D.O., & Holmes, L.D. (Eds.). (1972). *Aging and modernization*. New York: Appleton-Century-Crofts.

Katzman, R., Brown, T., Fuld, P., Peck, A., Schechter, R., & Schimmel, H. (1983). Validation of a short orientation-memory-concentration test of cognitive impairment. *American Journal of Psychiatry*, *140*, 734-39.

Lo, J.C. (1987). The changing patterns of household structure and economic status of the elderly: 1976-1985. Paper presented at the Conference on Economic Development and Social Welfare in Taiwan, Jan 6-8, 1987, at the Institute of Economics, Academia Sinica, Taipei, Taiwan.

Maddox, G.L., & Campbell, R.T. (1985). Scope, concepts, and methods in the study of aging. Pp. 3-31 in Handbook of Aging and the Social Sciences, edited by R. H. Binstock and E. Shanas, 2nd ed. New York: Van Nostrand Reinhold.

Rubington, E., & Weinberg, M.S. (1971). *The study of social problems*. New York: Oxford University Press.

Shanas, E., Townsend, P., Wedderburn, D., Friis, H., Milhoj, P., & Stehouwer, J. (1968). *Old People in three industrial societies*. New York: Atherton Press.

Shu, R.L., & Chang, Y. (1987). Single parent families in Taiwan: Their problems and prospects. *Chinese Journal of Sociology, 11* ,121-53.

Shu, R.L., & Lin, C. (1984). Family structure and industrialization in Taiwan. *California Sociologist, 7*, 197-212. [Family Structure and Social Change: A Follow- up Study. (1988).] Unpublished report for National Science Council Research project #NSC75-0301-H001-10.

Weiss, R. (1979). *Doing it alone*. New York: Basic Books.

CHAPTER 8

TAIPEI MUNICIPAL GOVERNMENT BUDGETARY ISSUES FOR ELDERLY SERVICES

Hsiu-hsiung Bai

Introduction

Ever since Taipei became a municipality under the direct jurisdiction of the Executive Yuan in 1967, a lasting endeavor has been in full swing, one that is heading for a "modern city" and serving as a model for the implementation of the Three Principles of the People. Two decades later, as a result of constructive achievements claimed by the municipal government and all citizens through their endless efforts, Taipei is about to become one of the world-class metropolitan areas, after being limited to a regional city.

Being one of the vital links to municipal progress, social welfare has achieved for itself a solid ground, by coordinating the present state of social policy which originated in the Principle of the People's Livelihood Scheme in 1965 to promote the related programs, establish social welfare funds, and develop professional social workers, which has also resulted in upgrading economic prosperity and social development. Now this social progress is aiming to make Taipei a city of welfare.

In coping with the ever-increasing aged population and satisfying various welfare requirements for the aged, programs concerning welfare for the aged sponsored by the Taipei municipal government have evolved from the passive relief activities in transition to an active nature, promising more development. Innovative service measures have been carried out in accordance with the needs of the old people, as an annual budget has been prepared by a well-planned administration. Even support from the community is being called for in a joint effort to push service programs for the welfare of the aged.

TAIPEI MUNICIPAL GOVERNMENT BUDGETARY ISSUES FOR ELDERLY SERVICES

The Aging Population

The population of Taipei is growing at a fast pace. In 1945, when Taiwan was recovered from the Japanese, there were only 260,000 people in Taipei. The population swelled to 790,000 in 1958 and 1,580,000 in 1968, after having become a special municipality as some nearby towns and villages were incorporated. Since then, an ever increasing Taipei population has been evolving, as indicated in Table 1, totaling 2.63 million in 1987 -- a growth of 64.6% over twenty years. This development, accompanied by other elements, has contributed to the rapid expansion of all municipal functions, with Taipei becoming the metropolitan center of the Republic of China, while at the same time serving as the center of its politics, economy, and culture.

Furthermore, progress made in the fields of public health and medical care areas along with the great improvements realized in nutrition and in the living environment, has resulted in a life expectancy for Taipei citizens of 75.09 years for men and 78.76 for women in 1986 -- compared to 69.28 and 72.81, respectively, in 1967, as indicated in Table 2.

From Table 1, we can see that there were only 37,390, or 2.33 percent of the total population in 1968, who were more than 65 years old; and 145,966 persons in 1987, amounting to 5.64 percent of the total population, thus more than doubling in just two decades.

The prolongation of the life expectancy for Taipei citizens is evidence of an aging society. What should be done to cope with problems resulting from this major transition in society? How do we satisfy the social needs of such large numbers of the aged?

TABLE 1

Growth of Aging Population (Over 65) in Taipei, 1968-87

Year	Population	Population Over 65	Percent
1968	1,604,543	37,390	2.33
1969	1,712,108	41,522	2.43
1970	1,769,568	43,240	2.44
1971	1,839,641	47,949	2.61
1972	1,909,067	52,006	2.72
1973	1,958,396	55,679	2.84
1974	2,003,604	59,953	2.99
1975	2,043,318	63,342	3.10
1976	2,089,288	67,850	3.25
1977	2,127,625	74,266	3.49
1978	2,163,605	79,673	3.68
1979	2,196,237	85,290	3.88
1980	2,220,427	90,482	4.08
1981	2,270,983	97,220	4.28
1982	2,327,641	104,615	4.50
1983	2,388,374	109,579	4.59
1984	2,449,702	118,098	4.82
1985	2,507,620	127,944	5.10
1986	2,575,180	136,179	5.29
1987	2,637,100	145,966	5.64

Source: General Review of Statistics of Taipei, 1987; Accounts and Statistics Department, Municipal Government of Taipei, pp. 68-73.

TABLE 2

Life Expectancy of Taipei Citizens

Year	Men	Women
1967	69.28	72.81
1971	70.07	74.20
1976	72.05	76.56
1981	73.09	77.75
1986	75.05	78.76

Source: Annual Report on Public Hygiene of Taipei for Fiscal Year of 1987, published in March, 1988, by Public Health Bureau of Taipei Municipal Government, p. 6.

Issues and Needs of the Elderly

Trends in the needs and the core of issues can be discovered through surveys and studies, such as the following report's analyses concerning the welfare for the aged from Taipei:

1. According to a survey completed in 1981 on the needs of Taipei citizens, public subsistence facilities for the aged, various kinds of discounts in daily life, expansion of recreation centers, and a free physical check-up and medicare benefits were stressed. In 1985, in a survey on goals for municipal progress, citizens in Taipei emphasized that social welfare measures should be intensified, among them welfare for the aged, which topped all other goals. All these results were taken into serious consideration by the municipal government and based on them, policy was shaped and actively supplemented with very encouraging achievements.

2. The Ministry of Interior also conducted a survey in 1983 of the welfare needs of a sample of old people over 70 in Taiwan in the Taipei area. The welfare measures calling for priority of the opinions of the aged were as follows:

(1) Self-supporting housing centers: building more facilities of self-supporting housing centers, increasing the allowance for the old who are poor, and supporting daily life at home.

(2) Recreational and entertainment activities: establishing more recreational centers and improving the community entertainment programs for the aged.

(3) Medical services: free physical check-ups, medical bills discount, and the erection of medical institutions exclusively for older patients. (Yue, 1983)

3. An assessment made in 1984 by the municipal government of Taipei on the welfare measures found that items mostly sought by the aged were, in priority order, as follows:

(1) discount allowance for medical bills,
(2) establishment of medical care institutions,
(3) increase in the number of recreational centers,
(4) increase in the subsistence facilities,
(5) provision for in-home services,
(6) offering psychological consultant services,
(7) improvement of homes on the basis of self-support,
(8) employment service

From the above, we can see that the older people place high value on medical care, health, and recreational activities, as well as a reasonable subsistence (Jay, 1985).

4. Again in 1986, a sample of citizens over 70 in Taipei were interviewed in a survey sponsored by the Bureau of Social Affairs of Taipei Municipal Government (28,012 persons) (Bai, 1987). Their needs are itemized in the order of priority:

(1) medical care (38%)
(2) financial subsidy (17.8%)
(3) recreational activities (16.5%)
(4) home visits (14.4%)
(5) subsistence services (12.1%)
(6) others (1.2%)

TAIPEI MUNICIPAL GOVERNMENT BUDGETARY ISSUES FOR ELDERLY SERVICES

As indicated in the above reports, we can see what the needs are and what items of services older people are urgently looking for, and which can be used as the framework for planning service programs for the aged. In Table 3, eight items have been categorized for the solutions of issues confronting old people physically, psychologically, economically, and culturally, as a budget has been prepared to implement them. In the meantime, a full-scale development program is to be made related to welfare services for the aged, while different phases are worked out aiming at short, medium, and long-term service programs so that the whole plan may be carried out systematically, item by item. Eight items involved herein are medical care, housing arrangement, recreation, financial subsidy, home visits, study programs, in-home service, and "involvement services," with each item being presented with "highlights" to be performed.

TABLE 3
Itemized Requirements and Service Highlights for the Old People of Taipei

Issue	Itemized Requirement	"Service Highlights"
Physical	Medical Care	Free check-up, Medical bill discount, establishment of remedial institutions.
Physical	Housing Arrangements	Expansion of public subsistence economic facilities, establishment of self supportive subsistence center.
Physical Psychological Social	Recreational Activities	Increasing the number of recreational centers for the aged, strengthening of the contents of community activities.
Economic	Financial Subsidy	Increasing the living allowance for the poor, strengthening of care for low-income elderly, providing job opportunities.
Psychological Social	Home Visits	Recitation of the good of the aged, sponsoring activities paying tribute to the aged.
Psychological Social	Study Programs	Expanding the educational programs of Evergreen Academy, sponsoring pre-graduate courses.
Physical Psychological Economic	In-home Services	Strengthening of the working scope of in-home services, and training of social workers.
Psychological	Involvement Services	Expanding activities of Evergreen Honor Service Crops, study of utilization of manpower of the aged.

TAIPEI MUNICIPAL GOVERNMENT BUDGETARY ISSUES FOR ELDERLY SERVICES

Development and Prospects of Service Programs For The Aged

Based on the "Social Policy at the Present Phase of the Implementation of the Principle of People's Livelihood," enacted by the Central Government in 1965, social welfare works have been actively promoted in Taipei. Before the city had been upgraded to a special municipality, a target of "Social RELIEF" had been set for the social welfare works. Its scope has been expanded after 1967, when Taipei changed its jurisdiction under the Executive Yuan, as passive help became active guidance, and partial subsidy turned into full-scale involvement, with resources from the community incorporated for joint involvement under the direction of the central government.

Steps toward the implementation of the developed programs by the Taipei Municipal Government for the social welfare are measured, accumulative, and on-going. During the following two decades since the transformation, Project An Kang (1972-1984) and "1st Phase of 6-year Medium Project" (1983-1988) were initiated. As for the present, a second 6-year medium project is actively under planning, and a year-2000-oriented long-term project is being attempted. The progressive development can be seen in both of the projects stated above for the aged in Taipei. A description of these is as follows:

1. An Kang Project (1972-1984)

Since its official implementation in 1972, the major purposes have been improving the lives of the poor, guidance for the poor to be self-supportive and independent, making sure that all children are cared for, providing decent jobs for the young, making sure the aged are well-supported, that the sick and disabled are well taken care of, and that the poor are properly housed. The project has been initiated by taking care of the aged, the weak, the poor, and the sick. The An Kang Project has been carried out in three phases: the short-term (1973-1976); the medium-term (1977-1980); and the long-term (1981-1984). Key issues to be implemented for each phase were as follows:

(l) For the Short Range

By achieving the assigned target calling for expansion of social relief, to assist the sick and single old people by taking measures such as:

i. increasing the living allowance,
ii. giving free medical care,
iii. improving and enlarging the facilities for subsistences for the aged;
iv. helping to expand the Home of the Honorable Homes to accommodate the single veterans, and
v. expanding low-cost housing for the poor to have free shelter.

This phase of services for the welfare of the aged emphasizes the satisfaction of the requirements for financial assistance, and the establishment of subsistence and medical care, particularly in subitem iii. The construction of the municipal Kwang Tse Kindness Institution in 1969 is worth mentioning here. During this stage, the boarding facilities have been expanded so as to accommodate many more of the poor and old people, as the private AI AI Institution has been provided for in increasing facilities to help accommodate helpless old people.

(2) For the Medium Range

The following goals remain to be completed in the short-range plan such as:

i. enlarging the scope for administering the medical care service for the poor, old people,
ii. continuing to help in the care and support of the poor, the elderly, and the weak,
iii. developing projects for bargain apartments,
iv. adjusting the living allowance for poor families, and
v. generating community-service programs to show tender care for the more helpless old people.

The emphasis here is the same as in the first range; however, another feature is to offer a broader consideration of those who need help from the poor up to those with low income. The service scope in daily life also has been expanded by utilizing volunteers from the community to look after the aged.

(3) For the Long Range

Act of the Welfare for the Aged, Acts of Social Relief, and Act for the Welfare of the Disabled have been consecutively enacted since 1980, and a more solid and concrete ground is given for making assignments concerning the welfare for the aged. After eight years of hard work for the short and the medium ranges of An Kang Project, the significant outcome is in view when the target of "helping the poor" has been achieved. This long range phase enters the Eighties requiring a more determined and more detailed planning target to be specifically identified, considering the transition and needs of the social environment to be coped with, and coordination of acts concerning the welfare of the aged.

The assignment of seeing that a program for accommodating the aged so they can be living well for the rest of their lives requires the establishment of self-supportive centers. As for the goal set for medical care, an implementation of a health management card at full scale for the male over 70 shall be completed while goals dealing with the implementation of financial assistance shall make sure that the sum of money to be increased can cope with the rise of commodity prices. All these conclusions at this stage are more innovative than those in the medium range while the scope of service has been expanded and the service quality promoted. Since the first term of the medium-range plans has been incorporated into this range, the measures for the welfare of the aged no longer carry their simple plan of helping the poor, as diversified functioning of full-scale care, promotion of service quality, and enrichment of the spiritual life are expected (Report on the Implementation of An Kang Project, 1975; Two Decades After the Transformation of Taipei, 1988).

2. Three Terms in Six-year Medium Range Project (1983-2000)

Completion is designated by the advent of the 21st century for the Taipei social welfare plan, which is divided into three terms of medium-range projects to be carried out within six years, the first term to start in 1983 and end in 1988; the second to fall between 1989 and 1994, with the third to be initiated in 1995 and finalized in 2000. With the completion of the first term, the next one is under planning, while the third term, viewed from the present situation, can be deemed as long range. In order to analyze and emphasize an integrated development scheme, the first term of the project will be treated as the already finished short range, the second as the medium range to be executed, and the third as the long-range goals to be achieved.

(I) Short-range Project (1983-1988)

Supplementary to what has already been discussed in the previous sections and based on the reports of outcomes from surveys on the welfare requirements for the aged during 1981-1987, a summary has been organized with eight itemized requirements as follows:

i. Medical Care: As early as 1973, plans for serving the medical needs of the old people living in Taipei have been formulated, in which clinical health and medical care as well as the implementation of physical check-ups were available at the local Health Office with free or discounted charge for medicine and care. In 1981, the health management card for those over 70 years old was implemented, featuring a periodic visit by qualified nurses for health guidance and check-up, in-house nursing, and psychological consultation. Until 1987, 44,440 persons of 71,366 of those over 70 years old have been served by such health cards, a 62.7 percent rate. Of those over 65 years old, 183,634 have received their free physical check-ups, averaging 1.26 times per person, thanks to the Preventive Plans for Health of the Middle and Old people unveiled in 1984, providing free check-up and medical care and promoting the in-house nursing services, which were evidenced by ninety sessions of in-house nursing training programs with total trainees of 3,593 persons. Table 4 shows the comparison of times for providing medical-care services to the old people and related expenditures during 1975-1987. According to a special favored program on the medical bills for the old people in Taipei implemented in the year of 1984, those who were over 70 were allowed a discount. In 1987, the completion of the Kwang Tse Kindness Institution's newly opened "Accommodation Center" provided an extra 122 beds for seriously disabled aged people to be granted medical care.

TABLE 4

Related Expenditure in Taipei during 1975-1987

Year	Times of Services Per Person	Averaged Times Per Person	Expenditure (NT$) Spent for Services	Average Expenditures Per Person
1975	28,652	0.45	992,982	15.68
1976	35,767	0.53	997,109	14.70
1977	57,632	0.78	4,800,502	64.64
1978	72,596	0.91	5,146,688	64.60
1979	84,421	0.99	5,483,711	64.30
1980	92,815	1.03	6,322,511	69.88
1981	116,421	1.20	7,274,582	74.83
1982	139,423	1.33	8,631,499	82.51
1983	141,104	1.29	10,116,503	92.31
1984	137,728	1.17	10,462,748	88.60
1985	158,651	1.24	10,577,913	82.68
1986	154,536	1.14	12,176,020	89.41
1987	183,634	1.25	13,300,554	91.12

*The population of people over 65 to each corresponding year as shown in Table 1. Source: pp. 54-55, same as Table 2.

ii. Settlement for Subsistence: Built in 1969, Kwang Tse Kindness Institution until now has received a total of 1,212 helpless old persons who have been provided with free care and services. Hau Nan Home for the Aged was added in 1986 with the same mission, and it has accommodated 414 persons. Another 400 persons can be expected to be received when the second addition under construction is completed with improvements of various living facilities. In the private sector, 148 have been received under public financing of constructional projects with the hope of receiving many more. The first self-support accommodation institution, built in 1983, is now receiving 100 aged persons who were found to be in need of self-support. Another 230 persons will be settled when the second term of construction is completed. Therefore, another 730 older persons have been served during the short-range project for the elderly.

iii. Recreational Activities: Four recreational centers named after the four directions -- East, West, South, and North -- have been constructed, and social groups organized to provide places for the old people to socialize, study, plan artistic shows with works of their own and enjoy friendly competition. Other programs offering tours and seminars are also held. Evergreen Club came into existence to encourage the elderly to work out an association group within the community so that those who have similar tastes may get together often. There are 51 Evergreen Clubs within 137 communities in Taipei, and more old people are encouraged to join to improve their leisure lives.

iv. Financial Aids: Old people staying in the institution receive a monthly allowance besides the caring services of subsistence, medical care, and recreational activities. The sum of the allowance will be adjusted according to the level of commodity prices.

Old people with low incomes are provided with a monthly living expense and permission to apply for accommodations in public apartments on lease terms but without any payment to be collected. Living outside is also encouraged by the institutions accommodating the poor elderly, who can board outside the institution and live in the community while the monthly living allowance can be claimed as usual. For the poor and sick old people, emergency relief monies, allowance for the burial ceremony, and medical bill discounts are made available; for the psychotics, medical care is free while rental clearance is partially publicly subsidized. Programs for helping the aged find jobs so as to increase their income are under planning.

v. Goodwill Visits: Since 1981, all the elderly who have reached 70 are given a "complimentary card" entitling them to all statutory benefits set forth in the Act of the Welfare for the Aged. Starting in 1983, a free ride on municipal buses is granted as a more pragmatic measure for attending to the needs of the aged. On each lunar calendar day, tributes are paid to the aged by sponsoring a "Season for the Aged" series of activities by the government, which has received feedback from the general public to bring their attention to honoring and respecting the aged. In 1987, the "Season" was highlighted with a visit to each of the 83,018 old people over 70 by the social workers who presented each a tribute in cash and a service manual. The models chosen have been publicly praised, and those over 100 are visited by the Mayor in person. Other activities include offering exclusive transportation facilities, summer study programs, celebration for the couples enjoying their Golden Wedding anniversary, and mountain hiking, included within the category of "recreational activities", a series of seminars presented on the subsistence and accommodation for the aged, in-house nursing care as included in the category of "medical care", and exhibition of works from Evergreen Academy. Various talent shows and competitions are sponsored for the category of "talent display", while the "social services" head a series of lectures on the welfare requirements, planning for the utilization of the manpower of the aged. All of the above programs are very much welcomed by the aged.

vi. Study Programs: At the recreational center of each Evergreen Academy, a study program has been underway since 1983. Courses in language, Chinese painting, graphical and ceramic arts, gardening, Chinese opera, and comprehensive talents have been offered, totaling 135 sessions by the end of 1987. A total of 3,566 students have enrolled in the courses with each issued a memorial graduate certificate

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carrying the statement: "Never too late to learn; experience creates knowledge." In 1987, a preparatory course for college-level work was initiated to send old people into college for further studies or simply to be audit students. There are six classes with 46 students, together with another summer session designed to enroll 60 students. Both are very well received by the old people who have set high goals for themselves.

vii. In-home Services: This service program was started in 1983 for those old people who live alone in unfortunate circumstances to receive medical treatment, mental support, and leisure activities. Persons responsible for these jobs are on a contract basis under the supervision of the social workers. The service corps are given their assignments for each designated district. A monthly average of 1,640 services are provided for those who are unable to be accepted by the accommodation facilities for help in their daily lives. Besides, personnel for nursing care are recruited to strengthen the in-home service jobs.

viii. Voluntary Services: This voluntary service system began in 1984 by openly recruiting service personnel through encouraging those who were retired from their work to form the Evergreen Honor Service Corps. They were sent to the recreational center in each district, accommodation centers, bargain-priced apartments, and each community to go ahead with each welfare service assignment. In 1987, an exclusive telephone line called "Evergreen Hearty Talk" became operative for providing consultation service to the old people cared for by the voluntary workers. A unit for the study and planning of the manipulation of the manpower of the aged was set up, which led to the trial operation of a Manpower Bank with the hope of expanding the service assignment done by voluntary old people and to coordinate with job guidance units to help the old people with their second career.

From the above explicated matter, we learn that since 1980 many innovative programs have been provided through the welfare service assignments. Not only the scope of rendering care and help has enlarged, but the efforts have been sufficiently active for the promotion of service quality and contents of assignment so as to broaden the assignments to an even larger scope.

(2) Medium-range Project (1989-1994)

Since the blueprint for the welfare assignment for the aged has already been formed by the short-range projects, it has also provided many valuable working experiences. Based on this same plan, an additional, even better plan is expected to be accomplished during this project. Again, requirements for the aged will be explicated by dividing them into the following eight items:

i. Medical Care: Donations from the general public will be incorporated into the public budget for the implementation of medical subsidy for the aged. Specific monies are to be given to those old people who are suffering major ailments or chronic diseases to reinforce their medical care. An exclusive clinical service at each municipal comprehensive hospital shall be established, or a hospital exclusively for the aged which will be more convenient so as to provide a popular service; furthermore, a medical care service network shall be formed to interface with three units from each health office, comprehensive hospital, and exclusive hospital to offer better medical care and nursing service for the aged.

More attention is to be paid to the implementation of preventive measures against disease for the middle-aged people by introducing the idea that prevention is better than cure, particularly with respect to two major assignments of intensifying the in-house nursing care and prevention of major chronic diseases such as diabetes and hypertension. Besides, the number of accommodation facilities shall be increased to render consultation to those private ones, and place the same under their supervision.

ii. Settlement: Expansion projects to be initiated for all those institutions, which are either free or charge a fee for the accommodation of the aged, are included in the short-range project so more of the aged can be accommodated while the facilities can be enlarged to promote the service quality, with the major emphasis on the promotion of mental health. Based on the tendency of the increasing numbers of self-supportive institutions, plans for their management and future direction of development as well as their organizational guidelines shall be clearly defined. Meanwhile, private groups such as the temples and churches shall be encouraged to finance the establishments of community accommodation centers for the development of modes of community care.

iii. Recreational Activities: Activity centers remain to be built and to enrich their programs by setting up a leisure service network to achieve the targets of being serviceable and diversified. Plans for the implementation of an "old people-sitting" service and "free luncheons for the aged" shall be considered while the exclusive telephone line for Evergreen Hearty Talk shall be enlarged with its function of providing consultation service as well as the service of exclusive transportation service for the aged. There will be the assurance, too, that there is no interruption to the community in making the Evergreen Club more popular by offering much more space and opportunities for the involvement of the aged.

iv. Financial Aids: Promote each living expense allowance for those old people with low income and seek a wider range for managing those institutions that are carrying out the program of "living outside." Prepare and propose the pension system for retired people, with guidance rendered to help those old people who would like a second job opportunity, as well as information about other fields like investment, monetary management, and second self-employment.

v. Goodwill Visits: Promote among young people the traditional virtues of supporting their parents in their own family and paying high regard to the aged by taking advantage of the mass communication media to publicize the realistic involvement of sharing love and care. Further, the well-grounded welfare measures shall be worked out to bring real, substantial help to the aged. Promote a sponsored season for the elderly each year to cope with needs of the aged and promote the social education function, accompanied by a series of activities featuring the innovative and practical.

vi. Study Programs: In order to fulfill the needs of the aged for free option and allow a wider scope of learning, the Evergreen Academy study session at the recreational center will be expanded by offering courses divided into long-term (10 months) and short-term (3 months) durations with arrangements made with most of the colleges and universities to offer more summer sessions and pre-graduate study programs (with academic credits either awarded or audited) and professional courses and comprehensive studies provided, depending on individual specialties offered by the responding colleges.

vii. In-home Services: To be expanded by employing more in-home service personnel and contracting with civil institutions for training programs, causing this service to be widespread among communities with improvements made to medical and nursing care areas by securing more financial support, manpower resources, and involvement from the private sector.

viii. Voluntary Service: To be emphasized by planning more effective elderly manpower utilization and by seeking the popularized setting-up of Manpower of the Old Hands Bank to contact those coordinated job consultant agencies for more exclusive attention to the promotion of voluntary services and job offerings to help the aged.

(3) Long-range Project (1995-2000)

The objectives of the municipal plans for Taipei are designed to create a city of vitality, order, and courtesy as embodied in traditional Chinese culture, combined with the development of modern technology. Therefore, among those targets, promoting the social welfare is one of the most important, with emphasis on the welfare for the aged as top priority. To be a Welfare metropolis carrying also its economic and social responsibilities missions, Taipei aims for the year 2000, as an index to its long-term project, to fulfill a series of municipal administrative decisions based on long-range strategical action solutions and planning. The eight items serving these purposes are:

i. Medical Care: Planning and implementation of health insurance programs on a trial basis, seeking more facilities to be constructed, aiming to provide exclusive medical care for those ailments that aged are vulnerable to, thus making sure that sick, old people can receive thorough care. Also plans for the health maintenance programs for the aged will be strengthened so as to promote "long life and health" for them.

ii. Settlement: More efforts to be put on the family-support system to emphasize the traditional ethics of being respectful and obedient to elders by promoting the nursing-care system within the community, including the community accomodation center, apartments for the aged, and daytime care centers, hoping to spark an awareness of mutual care and benefits among communities. Improving the accommodation facilities for the aged by having the institution adopt small units with categorized cares (for healthy as well as the minor and seriously disabled); as the self-supportive accommodation centers are expanded, the service quality will be promoted to meet requirements of the aged.

iii. Recreational Activities: Seeking the completion of a service network for recreational activities by coordination with the active functions of the Evergreen Club in each community to achieve the working goals that "activity be popularized, involvement generalized, and consultant services professionalized."

iv. Financial Aids: Investigation of the possibility of the implementation of a pension system for the aged while the social relief scope is enlarged for the aged so as to fulfill the economic needs of the aged to free them from being economically "insufficient".

v. Caring Visits: Exercise firm control over the case study of the low income aged receiving consultation for the material functions of caring and help. During in-home services, realize substantial assistance to the low-income aged while frequent schedules of paying tributes to the aged are sponsored by encouraging the aged to get more involved. Survey on the needs of the aged will be conducted to build service programs of solid effectiveness.

vi. Study Programs: The courses available at the Evergreen Academy will be enriched so that learning opportunities for the aged may be expanded and educational programs exclusively for the aged within each community may be promoted by utilizing connections with schools, libraries, and culture centers to provide sufficient locations and facilities. The level for further studies will be upgraded, based on principles for encouraging more of the aged to be involved so they can contribute further to society.

vii. In-home Service: To establish the in-house service network using the community medical-care welfare center as the base with emphasis on in-home service, recreation, and leisure activities, medical care, accommodation and financial aid for the system body to form an interfacing network, making the in-home mission actually bring benefits to the aged while expanding services to those old people supported by their families. Also, private in-home service agencies shall be encouraged to build up service efficiency.

viii. Voluntary Service: Gearing up to promote the utilization of elderly manpower by publicizing the Manpower of the Old Hands Bank and enriching the organization of Evergreen Honor Service Corps to unveil a series of voluntary service assignments and help the aged to secure a second career. Welfare assignments for the old in Taipei are well planned, with each service implementation oriented to the needs of the aged while the systemization of assignments and establishment of service network are aimed at all needs.

Preparation of the Budget for the Welfare of the Aged by the Society Agency of Taipei Municipal Government during 1986-1989

Budget preparation adopts the baseline of the "planning budget system"; that is, each project or program is pre-determined and financed in the parameters of the fiscal-year budget. As indicated in Table 5, such functioning is explicated by the budget preparation and execution with personnel and administration expenditure excluded for the promotion of the assignments of welfare for the aged by the Bureau of Social Affairs during a four year period from 1986-1989. This description is presented within the five categories of medical care, accommodation, recreational activities, caring visits, and financial aid while the study programs and service involvement are included in the item under recreational activities with the in-house service to be indirectly related to the operation of caring visits. However, the operational capital secured from the civil power and social resources is not included, as all the budgets are expressively listed in the corresponding fiscal year to be submitted for the examination and approval of the city council before being executed according to the annual administrative plans worked out by the municipal government. In preparation for Table 5, there are several points that must be clarified:

1. Both budget preparation and the final budget are presented for the years 1986 and 1987 while the final budget for 1988 is still pending the approval of the city council, although the budget preparation has been recently approved by the same. Some revision of the projects causing the increase in working capital explains why the amount of final budget exceeds that of the preparation.

2. There were huge amounts of budget involved in the implementation of accommodation in 1986 and 1987, resulting from the construction projects of the second term of the Hau Nan Accommodation Center and the self-supporting accommodation center, while after 1988 only items of facilities and maintenance expenditure for the same have been prepared since the completion of such projects. As for the budget preparation for the self-supportive center, only portions for the facilities have been prepared as the city council requires that it should be self-sufficient for operation. This explains why the amount for this budget is so low.

3. Larger amounts in the budgets for recreational activities in 1986 and 1987 were prepared since the construction and facility expenditure required for the South and the North Evergreen Recreational Center remained to be completed and have been reduced significantly after 1988. Still a large increase in the subsidy for the community to operate Evergreen Club has been approved by following the resolution of the city council who would like to see the functions of such a club expanded. Actually, there has been no reduction of the recreational activities for the aged, if the incorporation of the resources from civil involvement for their contributions is taken into considera-

tion. Although only a small portion of the budget has been approved, the utilization of civil power helps to keep the recreational activities in full swing.

4. When dealing with the budget for caring visits, the offering of free rides on city buses for those over 70 and the donation of cash as tributes to the aged consume the lion's share while the municipal government has to assume half of the expenditure of the free rides with the other half absorbed by the bus companies. Certainly, the disabled are not left alone for these benefits. Given the donation of cash at NT $200.00 to the aged over 70 by caring visits from social workers to the aged each year, and given the fact the number of the aged over 70 keeps increasing each year, this causes expenditures to keep rising.

5. Among the expenses involved in the implementation of financial aid, the living allowance collected by the listed domicile (75% are among the aged) used up the largest portion, which experienced the greatest growth as the number of beneficiaries increased while the amount provided has increased from the original monthly $1,200 per person to $1,800 in 1988; and from $1,800 to $3,600 monthly in 1989 for those over 70. Funeral subsidy has also been increased from $15,000 per death up to $23,000.

6. In the comparison of the above-mentioned five categories, we can see that the demands for medical-care assistance tops all others, followed by the requirements of accommodation, with financial aid in third place; however, the expenditure calling for financial aid will exceed that of accommodation to become the item along with that of medical care which calls for the highest budget for the government. This comes at a time when the large-scale accommodation institutions will be gradually replaced by community caring modes, as well as the increased living allowance granted to those old people who are classified as being poor and helpless. As for the other two categories of recreational activities and caring visits, a significant amount of joint op-

eration expected from civil involvement remains as the decisive element for successful implementation.

7. In a comparison of the approximate percentage of the budget preparation for the welfare of the aged with that of the social welfare, in general, the former shall be the vital link which should be receiving more attention.

Table 5
Budget Preparation of Welfare for the Aged by Taipei Municipal Government

Fiscal Year Budget (NT$) Item	1986 Budget	1986 Final	1987 Budget	1987 Final	1988 Budget	1989 Budget
1 Ailments Prevention	12,468,000	12,468,000	12,468,000	13,300,554	20,964,000	25,824,000
Medical Aids (60%)	116,080,000	119,440,178	210,792,000	189,555,455	232,926,858	326,124,000
Sub-Total	128,548,000	131,616,198	223,260,000	202,856,009	253,890,858	351,948,000
% of Total Budget	33.3	35.7	39.7	40.1	52.2	53.9
2 Accommodation at						
Private Institution	11,510,000	6,967,550	13,370,000	7,185,000	14,500,000	14,432,000
Kwang Tse Yuan	64,037,258	55,072,041	71,228,662	57,804,931	76,714,000	95,023,117
Hau Nan Yuan	53,032,948	52,735,161	28,102,340	23,320,391	34,633,000	33,525,490
Self-supportive	44,290,000	44,290,000	117,283,320	117,283,320	931,000	52,800
Sub-Total	172,870,206	159,114,752	229,984,322	205,593,642	126,778,000	148,033,407
% of Total Budget	44.8	43.3	41.0	40.5	26.1	22.7
3 Evergreen Club Aids	150,000	150,000	150,000	150,000	420,000	120,000
Facilities & Activities	1,444,270	1,164,960	2,034,585	1,812,573	148,200	151,808
Sub-Total	1,594,270	1,314,960	2,184,535	1,962,573	548,200	271,808
% of Total Budget	0.4	0.4	0.4	0.4	0.1	0.1
4 Free Bus Ride	26,446,875	26,293,006	36,750,000	36,288,539	31,500,000	40,250,000
Give-away Cash & In-house Service	15,779,520	16,623,676	18,669,660	16,860,928	22,396,380	24,021,932
Sub-Total	42,226,395	42,916,682	55,419,660	53,149,467	53,896,380	64,271,932
% of Total Budget	11.2	11.6	9.9	10.5	11.1	9.8
Remarks:	Besides the aged, there are many other subjects receiving benefits from service items such as medical aids, free bus rides, and living allowance, financial aid, domicile as well as the give-away cash for three major occasions on the Chinese Lunar Year, the Mid-Autumn festival and the day of Paying tributes to the Aged; therefore, the percentage for such respective budget has been calculated on an estimated basis, to figure out a rough percentage of 60% for the item Medical Aid in Category 1.					
5 Living Allowance Caring Domicile	32,400,000	26,355,375	40,500,000	33,405,570	37,260,000	70,800,000
Emergency Aid for Veter	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	3,000,000
Funeral Aid	600,000	550,000	3,000,000	3,000,000	4,500,000	7,000,000
Festival Occasion Compliments	5,183,550	4,522,250	5,289,550	5,114,850	8,224,000	7,098,800
Sub-Total	39,683,550	32,927,625	50,289,550	43,020,600	51,484,000	87,398,800
% of Total Budget	10.3	9.0	9.0	8.5	10.5	13.5
Total	385,922,421	367,890,217	561,133,517	506,582,291	486,597,438	652,423,947
Annual Budget Concerning Social Welfare Expenditure	1,000,194,222	924,373,357	1,208,897,481	1,101,688,668	1,206,919,148	1,508,477,809
% to the Total Social Welfare Budget	38.6	39.8	46.4	46.0	40.3	43.3

TAIPEI MUNICIPAL GOVERNMENT BUDGETARY ISSUES FOR ELDERLY SERVICES

Summary

In order to be prepared for coping with the coming of an aging society, the Bureau of Social Affairs of the Taipei municipal government will make all plans concerning the medical care, accommodations, recreational activities, financial aid, caring aid, study programs, in-house service and voluntary service based on the survey of the needs of the aged in these eight categories for the welfare of the old people. To follow up the planning started in 1981, such plans have been under implementation, and a follow-up to the administrative targets of the An Kang Project initiated at the time when Taipei became a special municipality in 1967 is to be completed by the year 2000 with a series of administration projects. This article attempts to elaborate the short, medium, and long range features of those plans with supporting materials from the budget preparation of the municipal government budget during 1986-1989.

Concerning the welfare for the aged, the major objectives are that all the aged are well-supported (financial aid, caring visits, and in-house service); that they are under good care (accommodation facilities); that they are healthy (medical care); that they enjoy their lives (recreational activities); and they are living with positive attitudes (study programs and service involvement). The goals of the Bureau of Social Affairs, through the planning and implementation of all these projects for the welfare of the aged, are meant to accomplish the above five objectives, and, at the same time help transform Taipei into a modern Welfare City.

References

1. Statistics Review of Taipei, 1987, Accounts and Statistics Department of Taipei Municipal Government, 1987.

2. Annual Report on the Implementation of Public Health of Taipei in the Fiscal Year of 1987; Health Office, Taipei Municipal Government, 1988.

3. Welfare for the Aged, by O Young Lian Yue, appeared in a Report on the R & D on the Ten-Year Project of Social Welfare, as contracted by the Ministry ofInterior with Taiwan Economic Institute, 1983.

4. Assessment of the Measures for the Welfare of the Aged and the Disabled in Taipei; Huan Jun Jay et al., under the request by Taipei Research and Examination Council, 1985.

5. Reports on the Manpower Resources Evaluation and Needs and Caring Visits for the Aged in Taipei; Hsiu-Hsiung Bai et al., published by the Bureau of Social Affairs of Taipei Municipal Government, 1987.

6. Marching Toward a Safe and Healthy Society -- a Report on the Implementation of An Kang Project, the Bureau of Social Affairs of Taipei Municipal Government, 1975.

7. Two Decades after the Transformation to a Special Municipality: Taipei, Taipei Municipal Government, 1988.

8. Report on the Census on Low Income Citizens of Taipei for the year of 1987, the Bureau of Soical Affairs of Taipei Municipal government, 1987.

CHAPTER 9

THE FAMILY AS A SOCIAL WELFARE SUPPORT SYSTEM FOR THE ELDERLY IN TAIPEI, TAIWAN, REPUBLIC OF CHINA

Shou-jung Yang

As the result of economic prosperity in Taiwan, the Republic of China, the life-span has generally expanded under advanced medical care and enriched nourishment. With it also comes the emergence of an aging society. According to a report entitled "Projection of the Population of Taiwan Area, Republic of China 1986 to 2011", conducted by the Manpower Planning Department, Council for Economic Planning and Development, Executive Yuan in 1988, the total population 65 years and over will reach 1,493,000 by the year 1994. The percentage of the population 65 years and over will reach 7.03%. The Taiwan area of Republic of China will have serious aging problems at that time.

By the year 2000, the population 65 years and over will reach 1,832,000, with a high percentage of 8.2% of the total population. In the year 2011, the population of 65 years and over will reach 2,322,000 with a percentage of 9.71% of the total population. Taiwan will become an aging society at that time.[1]

In order to solve the aging problems in Taiwan, to cope with the problems of an aging society, the Department of Social Affairs, Ministry of Interior, designed its strategy to meet the new challenge of aging problems:

A steady income: Many elderly persons enjoy dignity and satisfaction with a steady income, either from the support of their offspring, or from their own savings or investments. Those without family support are provided with a subsidy by government support.

A place to live in: Those who choose to live with their families will enjoy the pleasure of living under the same roof with their offspring. Those who are alone will enjoy living with other elderly in an apartment or public homes for the old; others may live in day-care centers.

Medical care for the sick: For those elderly with illnesses, some may already enjoy medical insurance, others will get free medical care, free physical examinations, or preferential medical service; for those clinical cases, there are in-home services, or elderly day-care services.

Spiritual enrichment: With a view to enriching the lives of the elderly so that they may live happily and fruitfully, there are all sorts of learning classes, cultural and entertainment centers, clubs and organizations for the elderly, recreation and entertainment facilities, morning group exercises, etc.

Paying respect: A special Elderly Day is set aside every year for the nation to pay respect to its elderly generation. Big dinner parties are offered to the old on their birthday; parks and museums and other public places and public transportation are half price (sometimes even free) to all elderly.[2]

For building of a better world for the elderly to live in, the tentative goal also should be emphasized in the near future with a vast amount of financial support by the government, e.g.,

- Establish a yearly pension for the elderly to provide financial security.
- Intensify medical assistance to the elderly to pave the way for universal medical care.
- Expand and construct various community facilities for the promotion of recreation and sporting activities.

- Assist the elderly in various communities to pursue knowledge and spiritual enrichment.
- Build up a working system for social workers engaging in elderly welfare services.
- Intensify ad hoc research plans for elderly welfare to meet the needs of the future aging society.[3]

Because of the special political situation in Taiwan, the government has to spend a large amount of money, over 50% of government expenditures, for national security. The government also has to invest a vast amount of money for economic development. Total social welfare expenditures are limited in this respect.

According to the Manpower Planning Department, the total percent of social welfare expenditure was 11.1% in 1980, 15.2% in 1983, and 15.7% in 1985. But these percentages are very low compared to the developed and some developing countries. They cannot fulfill the need for various social welfare programs, especially in solving aging problems in the future.

Respect for the old has been the traditional virtue of the Chinese culture in the way of paying tribute to the wisdom and efforts of the old generations for their contribution to the growth of the nation. In the ancient society, the elderly always enjoyed a highly respected authority in the family by means of their knowledge and moral character to teach, to influence the young generation, to serve as a model for the young with good behavior, and their authority to mediate disputes, and to keep the family in a peaceful and harmonious atmosphere. Today, with the approach of modern society, traditional values have undergone tremendous changes which might affect the solution of aging problems in the future. It is necessary to rebuild the family-centered concept.

THE FAMILY AS A SOCIAL WELFARE SUPPORT SYSTEM FOR THE ELDERLY IN TAIPEI, TAIWAN

In order to promote the family structure and functions to build a family-centered social welfare system, a study was sponsored by the Department of Social Affairs, Ministry of Interior, titled "Family as a Social Welfare Support System in Taipei". This chapter reports on part of the findings dealing with social welfare functions for the elderly of a family-support system in Taipei City.

Among the low-income groups of the residences in Taipei City which are under social assistance programs, a sample of 200 was selected. Stratified sampling methods were used in this study. The purpose of this study was to find out how the family structure of low-income groups of Taipei city and their family-support functions for the elderly in the family. Several questions were asked in this study to find the reactions of the low income people in Taipei City.

Table 1
Family Structure

	N	%
Nuclear Family	157	79.3
Extended Family	29	14.6
Large Family	12	6.1
Total	198	100.0

From Table 1, the results indicate that 79.3% of low-income persons were in nuclear families in Taipei City. Due to rapid social change, young people move from rural areas to build their new families in Taipei. For this reason, the family structure of low-income people consists of only 6.1% with a large, traditional family. Family-structure change from a large family to a nuclear one does not mean, however, that the family members do not have any responsibilities to their elderly. Only 23.9% of the total sample live with their parents (Table 2).

Table 2
Percent Living with Parents

	N	%
Yes	47	23.9
No	150	76.1
Total	197	100.0

Table 3
The Reasons for Not Living With Parents

	N	%
Parents live alone	21	14.0
Parents live with siblings	53	35.3
Parents live at residential home for the aged	2	1.3
Parents not living	55	36.7
Other reasons	19	12.7
Total	150	100.0

From Table 3, it can be seen clearly that the major reason for the parents not living with the respondents is that they live with their brothers or sisters; 36.7% of the sample's parents are no longer living. Only 1.3% of the parents live at residential homes for the aged. From the findings of this study, it is clear that the family still has an important role in taking care of their elderly. The children still are the major support of their parents.

Table 4
Family Functions

	N	%
Economic support	197	99.5
Education	59	29.8
Emotional support	175	88.4
Maturity	32	16.2
Religion	20	10.1
Protection	16	8.1
Entertainment	15	7.6

The most important function of the family is its economic support function with a high percentage of 99.5% (Table 4). Emotional support also has a high percentage of 88.4%. For the low-income people in the city area, family members tend to stick together to help each other, both financially and emotionally. Other family functions are less important, even the education function. Financial support from the Department of Social Affairs of Taipei City Government for those low income families to fulfill their economic-support function, along with their high emotional supporting function, might solve the elderly problems in the city area, especially in low income areas.

Table 5
Responsibility for Care of Elderly

	N	%
Children's duty	179	90.4
Elderly themselves	7	3.5
Government's duty	6	3.0
Others	6	3.0
Total	198	99.9

Ninety percent of the sample indicated that the children; i.e., the family, should have the responsibility of caring for their elderly parents. Only 3.5% felt that the elderly should take care of themselves, and 3% believed that the government should. This finding shows clearly that family members still maintain their traditional responsibilities to their elderly. The family remains the best support system of social welfare system for the elderly. It is necessary for the government, and related public and private organizations, to invest the funds and manpower, through professional social workers, to strengthen the family functions in order to solve aging problems in the future.

Even among those low-income people in Taipei City, 69.9% reported they can take care of their elderly without causing their own family any "burdens." The family plays a very important role in reducing aging problems even in the modernized city of Taipei. But the government still has to provide the financial support along with medical support for those families which do experience strains in caring for their elderly within the family.

The Department of Social Affairs of Taipei City Government, in reviewing aging problems and the specific functions of the family of low-income people in Taipei City, appropriated a large amount of money and manpower to provide a special program of in-family services for the low-income elderly. Special training programs were also organized to train in-family service workers and volunteers to help the family, without having to move these aged people from their family and community. With the fund's support, there are over 1,604 cases of in-family services each month, on the average. In order to promote this in-family service program and to extend this program to other moderate or even high-income families, the Department also has provided training programs to train paid in-family services workers to meet the requirement of the families in Taipei City.

But only 27.9% of the total sample of low income families know about in-family services provided by the Department. Clearly, this program needs intensive promotion to meet the needs of low income people. More than three-fourths of the sample believe that in-family service can solve their elderly problems inside the family. But still 23.6% of the sample have serious financial and medical problems which in-family services cannot resolve. In order to solve these medical and financial problems of low income people, the Department of Social Affairs also provides medical care programs for the elderly and a monthly payment for low-income people.

Table 6
Services or Programs that can Help in the Future

	N	%
Medical Care System	130	65.7
Update Welfare Law for the Aged	22	11.1
Promote In-family Service System	144	72.7
Provide Leisure Services	97	49.0
Provide Volunteer Work for Elderly	12	6.1
Financial Support System	33	16.7

Number in Sample: 198

Nearly 73 percent of the total sample reported that an in-family service program could help the family to solve their elderly's problems in the future (Table 6). Also, nearly 66 percent agreed that a medical care system can help low-income families to solve their elderly problems in the future. To set up a medical care system for the elderly, especially for low-income people, is very important in the future. The new development of establishing a Ministry of Health and Welfare at the Executive Yuan will help in this regard.

Nearly 50 percent of the total sample approve of the availability of leisure-activity services. Other desired programs include: (1) volunteer work for elderly; (2) a financial support system; and (3) updating the Welfare Law for the Aged, as important steps for solving aging problems in the future, as seen in Table 6.

THE FAMILY AS A SOCIAL WELFARE SUPPORT SYSTEM FOR THE ELDERLY IN TAIPEI, TAIWAN

This study indicates clearly that the family still plays a very important role as a social welfare supporting system for the elderly. The children still have the full responsibility to take care of their parents who live in the household, or who live with brothers or sisters. Very few people (less than 4 percent) feel that the elderly themselves should have responsibility. The percentage of parents living alone (14%) or living in residential homes for the aged (1.3%) is also very low, which indicates that in-family service programs for the elderly are very crucial.

The results also indicate that the Department of Social Affairs of Taipei City Government is already reviewing the aging problems of Taipei City, and has set up in-family service programs for low-income people. But the awareness level is low, due to limited financial support and manpower shortages. In-family service programs even extend to other income levels and should be important to solving the aging problems in the future.

Footnotes

1. Manpower Planning Department. Projections of the Population of the Taiwan area, Republic of China 1986 to 2011, executive Yuan, January 1988.

2. Department of Social Affairs. The Characteristics of Social Welfare for the Senior Citizens in the Republic of China, Ministry of Interiors, 1988.

3. Department of Social Affairs of Taipei City. Social Welfare Policies for Elderly in Taipei, Taipei City Government, 1988.

CHAPTER 10

NEED OF THE ELDERLY FOR HOME CARE SERVICES IN A CHANGING SOCIETY: THE CASE OF TAIPEI METROPOLITAN CITY

Hou-sheng Chan

Introduction

As the old people grow in number and in proportion to the population, the care for the elderly has attracted a great deal of attention of welfare policymakers, as well as the general public in societies where the aged have been facing more and more serious problems in their ordinary lives. In most industrial societies, it is evident that changes in the structure of the family have led to the transformation of the role played by the family in caring for the old people upon retirement age. Although the functional relationship between change in family structure and industrialization or urbanization has not yet been theoretically fully established, there is evidence that the responsibility to provide services or care for the old people has gradually been shifted from members of a family to the society.

Based on the concept of risk-sharing, it is assumed by quite a few people that care for the elderly is better undertaken by institutions other than their homes. However, there is also a substantial number of people holding different viewpoints. For example, it was once pointed out that "the underlying principle of our services for the old should be this: that the best place for old people is their own homes, with help from home service if need be" (Shanas, et al., 1968:104). Therefore, home help and home nursing have become the two most important domiciliary services for old people in many western industrial societies. Domiciliary services for the elderly have been supplemented by health visiting and meals services available for small minorities of the elderly population. Only those old people who are physically handicapped and thus need special care will be accommodated in residential homes provided through public and non-profit agencies.

It can be concluded from experiences of the care for the elderly in western industrial societies that welfare provision for the elderly has been developed into two patterns. The first pattern is the domiciliary services for those old people staying in their homes. The second pattern is the residential services for those old people who are neither able to take care of themselves nor cared for by home help, provided by social workers and health visitors. These two patterns of welfare provisions for the elderly can be seen as a reflection of state intervention into the supply of social services for the old people, as the function of the family has increasingly been dismantled, on the one hand, and the role of the state in the provision of social services for the old people has been enlarged, on the other.

These two patterns of welfare provisions for the elderly in industrial societies have been introduced into industrializing societies with the assumption that the structure and function of the family has begun to change as a result of industrialization and urbanization as observed in western societies in the beginning of this century. Therefore, the old people in "industrializing" societies are in need of these patterns of social services developed in industrial societies.

This chapter is basically designed to examine the following thesis drawn out of the development of welfare provisions for the elderly in the western societies: with the growing number of old people and change in family structure, old people will need more domiciliary services as well as residential care. In other words, this chapter intends to look at what needs of the elderly population have been emerging in the course of urbanization in Taipei. The following examination is made on the basis of the findings of an empirical study undertaken in 1986-87 in the Taipei Metropolitan area.

Needs of the Elderly for Home Care Services in Taipei

Taiwan has observed a sequence of changes in its societal, economic, and political structure in the past thirty-five years. It is sometimes suggested that the family structure in Taiwan has undergone significant change since 1950; e.g., from a traditional extended family pattern into a nuclear one, in particular, in view of the housing design in urban areas which appears to be more adequate for a nuclear size family rather than an extended one.

With regard to the needs of the elderly for home services in Taiwan, in particular in urban cities, many empirical studies undertaken in the past years in different cities of Taiwan have drawn quite a similar conclusion (Chen, 1984; Chou, 1985; DGBAS, 1987). These studies all indicate that over half of the elderly in cities prefer to stay with their children, more than 35% prefer to stay nearby their children but in independent housing, and less than 15% of the elderly prefer to stay alone (Hsu, 1986). In other words, even though the modernization process has taken place for quite some time, the great majority of the elderly in Taiwan still prefer to stay with or close to their children. The proportion of the elderly who are willing to move into residential homes for care has been small, and it was less than 3% in 1987 (DGBAS, 1987). On the other hand, less than 1% of the total elderly population were staying in residential institutions in Taiwan in 1988, which is far less than their counterparts in Britain and the United States (Shanas, et al., 1968:). These statistics indicate that the old people in Taiwan are mostly staying with their children partly due to their reluctance to stay alone or the lack of residential facilities.

Our Taipei Study on Gerontology has a similar finding. Within the Taipei metropolitan area, 78.7% of the sampled old people are willing to stay with their children, and 13.7% prefer to stay on their own (Table 1).

Table 1

The Willingness of Old People to Live with Married Children

Willing	78.7%
Unwilling	13.7
Depends on Conditions	7.6

As far as the needs of the elderly for home services are concerned, the following factors will directly or indirectly influence or even determine the rise of their needs: their living arrangements (whether staying alone or with children); their preference of living arrangements; their felt need; and their contact with the outside, etc. The following discussion will, therefore, be focused upon these factors.

First of all, the actual living pattern of old people in the Taipei metropolitan area is shown as follows:

Table 2

The Living Pattern of the Elderly in Taipei Metropolitan Area

Living with Children	73.8%
Not Living with Children	26.2

In other words, it can be assumed that about three quarters of the old people in the Taipei metropolitan area are living with their children. There are mainly three reasons which lead the elderly not to live with children (Table 3). The first one is that the elderly have no children, or children abroad. The second one is that children are married and move out. The third factor is that housing is too small to accommodate the elderly and their children.

Table 3

Reasons for the Elderly Living Alone

No Children or Children Abroad	40.0%
Children are Married and Move out	38.1
Housing is too Small	21.9

With this kind of housing arrangement, it is interesting to discover that 73.8% of the old people are satisfied with their living arrangements; however, 7.2% are dissatisfied (Table 4). These statistics may be interpreted as follows: the elderly are usually economically dependent, thus their degree of satisfaction with their living arrangement tends to be higher.

Table 4

Old People's Satisfaction with Their Living Arrangements

Satisfied	73.8%
No comment	19.0
Not Satisfied	7.2

This high degree of satisfaction with living arrangements of the old people in Taipei has been supported by the following finding: When old people are asked whether they wish to change their current living arrangement, no more than a quarter of the old people hold an affirmative attitude (Table 5), which can also be interpreted to mean that because the old people tend to be more conservative and dependent, they tend to be satisfied with their current living pattern.

Table 5

Whether Old People Wish to Change Their Current Living Pattern

Yes	9.8%
Do not mind	17.5
No	72.7

The kind of living arrangement the elderly prefer will determine their need of welfare provisions. The following table indicates the diversity of the preferences of the elderly for their living arrangements.

Table 6

The Living Pattern Preferred by Old People

Living alone	10.0%
Living with children	67.0
Living with Different Children in Different Places	6.4
Residential Institution	14.7
Others	1.8
	99.9

Although most of the elderly in Taipei are living with their children and close kin, they are still in great need of some kind of home care. When asked whether they need anyone to take care of them, over half of the responses are positive (Table 7), which suggests that old people living with their children still need some kind of home help.

Table 7

The Need for Elderly for Home Help

Need home help	56.5%
Do not need home help	43.5

When old people are asked if they need someone (including members of the family) to help them contact with others, their answers tend to be consistent with their need for home help (Table 8).

Table 8

The Need of the Elderly for Communicating with Others

Need help	37.9%
Do not need help	62.1

Finally, when the old people are asked to express what need they feel is most important, their responses tend to focus on medical services, home services, and a great need of leisure activities (Table 9).

Table 9

The Felt Needs of the Elderly

No need	4.5
Medical and home services	17.9
Financial support	3.6
Mental support	1.0
Housing arrangements	2.1
Need for jobs	0.2
Need for leisure activities	70.6
	99.9

It can thus be seen from the table that the need of the elderly for recreation and leisure activities is far more than their need for home services. This result is mainly due to the fact that a great majority of the sampled old people are in good health. Their need for leisure and recreation activities tends to be overwhelmingly high.

Conclusion

As far as the need of the elderly for home care is concerned, these findings from the Taipei Study on Gerontology seem in some respect to support the proposed thesis that with the growing number of old people and changes in family, old people will need more home services as well as residential care. Although most of the old people still stay with their children in Taipei, it is also true that they need home services in the form of health visits and domiciliary care. At the same time, most of the households with old people are not well designed for disabled elderly people, for instance, without an elevator. These elderly will have to be confined in a small living environment and need extra home care services, even if they have children stay with them.

This brief chapter has not dealt with the supply side of home services provided through public welfare agencies as well as private or voluntary ones. But it can be imagined that, as pointed out by Qureshi and Walker (1986) in their assessment of caring for elderly people in Britain, with the growing increase of the need for care of the elderly and the limited supply of social service provisions, there is likely to be a growing "care-gap" between the needs of elderly people and the supply of informal carers, mainly provided by members of a family. From the above findings, it is clear that there is no care-gap between the needs of elderly people and the supply of informal carers in a family, as far as the old people in Taiwan are concerned. However, there are two factors which may contribute to this care-gap in the future. The first one is the family breakdown which is likely to have an impact on the future availability of carers at home. The second factor is the increased involvement of married women in the labor market which will reduce their commitment to care. This will cause a great concern in the welfare service agencies, both public and private, in the provision of home care services for them. This kind of service is currently at the stage of experimentation in Taipei and Kauhsiung cities.

References

Chen, Y.C. (1985). *The study of the problems of welfare for the elderly in Kauhsiung City*, Taichung: Social Welfare Research Centre, TungHai University.

Chou, W.L. (1984). *The study of welfare needs and living satisfaction of the elderly in Taipei City*. M.A. thesis, National Taiwan University.

DGBAS (Directorate-General of Budget, Accounting & Statistics).(1987). *Survey of the youth and the elderly in Taiwan area,Taipei:* DGBAS, Executive Yuan, ROC.

Qureshi, H. & Walker, A. (1986). Caring for elderly people: the family and the state. In C. Phillipson & A. Walker (Eds), *Ageing and social policy: A critical assessment.* London: Gower.

Ross, R. B., et al. (1985). *Welfare provision for the elderly and the role of the state.* London: Anglo-German Foundation for the Study of Industrial Society.

Shanas, E. et al. (1968). *Old people in three industrial societies.* New York: Atherton Press.

Tinker, A. (1984). *The elderly in modem society.* London: Longmann.

CHAPTER 11

SURVEY OF AN INTERDISCIPLINARY STUDY ON AGING IN TAIPEI: SAMPLE, INSTRUMENT AND INTERVIEW

Kao-Chiao Hsieh

During the past decades, Taiwan has experienced a rapid demographic transition with older populations gradually coming to play an important role in societal structure. Concurrently, the extended family, which is well-known as a strong supporter of the aged in the Chinese society, has weakened. These two events have caused political leaders and scholars to pay more attention to the aging problems.

In 1985, The Department of Humanistic and Social Science Development, National Science Council of the Republic of China, announced a research program for study of the elderly. A group of twelve persons was invited from the universities to submit a research proposal, and later formed a committee to deal with an Interdisciplinary Study on Aging. The author was a member of this group. The members of the committee also included those who were in the fields of medicine, public health, economics, psychology and sociology. From their own perspectives and interests, each member of the committee did his own research work. Each was funded by the National Science Council of the Republic of China. In order to accomplish the purpose of interdisciplinary integration, the members of the committee agreed to work together in a field survey and data collection, but each wrote his own report.

The work of this chapter is mainly concerned with how the survey produced the data for their research on aging. It focuses on three aspects of the survey: 1) sample design, 2) questionnaire construction and, 3) the field interview. The procedures and problems in these areas are described and discussed in depth in the paper, primarily the sample design.

Sample Design

Population. The population for this survey was noninstitutionalized persons 65 years old and over and living in Taipei city and Taipei county in 1986. By the end of 1986, the population of persons 65 and over in both Taipei city and Taipei county was 248,545. This group represents the population from which the survey sample was selected.

Sampling Frame. The list of registered households in which all the old people's names and addresses appeared was used as a sampling frame for the research.

Sampling. A two-stage sample was used in this research. The sampling unit for the first stage of sampling was the 'li' (neighborhood) and the 'tsun' (village). First, all 'li' and 'tsun' were put in order of urbanization level, then divided into three classes of high, middle and low. (The classification and standard were taken from the 1981 Handbook of 'li' and 'tsun' Household Registration Statistical Data). The results of the classification showed that among 1,421 li or 51 tsun of Taipei city and Taipei county all together, 1,162 li or 25 tsun were classified as highly urbanized communities, and 127 li or 13 tsun as low urbanized communities. Since all 630 li of Taipei city were included in the class of highly urbanized community, the highly urbanized communities were again divided into two classes: Taipei city and Taipei county. Secondly, from the highly urbanized communities of Taipei city and the high, middle and low urbanized communities of Taipei county, we randomly selected sample li or tsun, and the number of sample li or tsun in the four classes are 13, 12, 13 and 13, respectively.

In the second stage of sampling, the sampling unit was the household; systematic sampling was used to select sample households from the selected li or tsun. One-half of the households in each sample li or tsun was randomly selected as sample households. The person aged 65 and over in every sample household was assigned to the sample of old people for the research. If a household had two or three persons qualified for the sample of old people, a random sampling was used to select one. Through these procedures, 1,276 old people were selected in the highly urbanized communities of Taipei city; 756, 507, and 503 were respectively selected in the high, middle and low urbanized communities of Taipei county. All the old people selected totaled 3,042 which became the core sample of old people. (see Table 1)

From these households, approximately 3,000 persons were selected, broken down into the High, Middle, and Low levels of urbanization. From these 3,000 persons, 1,500 were interviewed for a 50% rate of participation. Of those who did not participate, 42% could not be located; only 2.2% declined to be interviewed. The 6% remainder of nonparticipants had the questionnaire answered by a friend or relative.

Table 1
Size of Population and Sample in The Variously Urbanized Communities

		Level of Urbanization			
	Total	Taipei City	Taipei County		
		High	High	Middle	Low
I Population					
(1) No. of li or tsun	1,421	630	532	127	132
(2) No. of old people	248,545	136,179	85,388	14,986	11,992
II Sample selected					
(1) # of li or tsun	51	13	12	13	13
(2) # of old people	3,042	1,276	756	507	503
III Sample interviewed in					
(1) questionnaire I	1,519	575	377	298	269
(2) questionnaire II	1,362	506	352	268	236
IV Sample selected/ Population	1.22%	0.94%	0.89%	3.38%	4.19%
V Sample interviewed/ Population					
(1) questionnaire I	0.61%	0.42%	0.48%	1.99%	2.24%
(2) questionnaire II	0.55%	0.37%	0.41%	1.79%	1.97%
VI Sample interviewed/ Population					
(1) questionnaire I	49.9%	45.1%	49.9%	58.5%	53.5%
(2) questionnaire II	44.8%	39.7%	46.6%	52.9%	46.9%

Note: Tables 1-5 were adapted from Dr. Tung-Liang Chiang, "A Statement of Sampling in the Inter-Disciplinary Study on Aging". May 2, 1988.

Table 2
Comparison Between Population and Sample Selected

	Population		Sample Selected	
	N	%	N	%
Total	248,545	100.0	3,042	100.0
Sex				
Male	135,806	54.6	1,676	55.1
Female	112,739	45.6	1,366	44.9
Age				
65-69	109,301	44.0	1,296	42.6
70-74	74,205	29.9	903	29.7
75-79	37913	15.3	391	1 2.9
80-84	18,521	7.4	351	11.5
85+	8,605	3.4	101	3.3
Urbanization Level				
Taipei City: High	136,179	54.8	1,276	41.9
Taipei Country: High	85,388	34.4	756	24.9
Middle	14,986	6.0	507	16.7
Low	11,992	4.8	503	16.5

Table 3
Comparison Between Population and Sample Selected, Taipei City

	Population		Sample Selected	
Age Group	Male	Female	Male	Female
65-69	34,911	24,768	362	22
70-74	22,940	17,827	206	172
75-79	10,570	10,126	87	89
80-84	4,740	5,363	36	56
85+	1,847	3,087	1	
Total	75,008	61,171	710	566

Table 4
Percentage Distribution of Sample by Interview Situations

		Level of Urbanization			
	Total	Taipei City	Taipei County		
		High	High	Middle	Low
Sample Selected	100.0 (3,042)	100.0 (1,276)	100.0 (756)	100.0 (507)	100.0 (503)
Questionnaire I (interviewed)	49.9 (1,519)	45.1 (575)	49.9 (377)	58.8 (298)	53.5 (269)
Questionnaire II (interviewed)	44.8 (1,362)	39.7 (506)	46.4 (352)	52.9 (268)	46.9 (236)
Partially Completed	6.7 (203)	8.5 (108)	4.8 (36)	7.5 (38)	8.2 (41)
Rejected	2.2 (66)	3.2 (41)	2.1 (16)	1.2 (6)	0.6 (3)
Not Located**	41.9 (1,276)	43.7 (558)	43.8 (331)	33.9 (172)	38.8 (195)
Answered by a Friend of Relatives***	4.4 (135)	4.9 (63)	2.8 (21)	4.5 (23)	5.6 (28)

Note: *including (1) uncompleted questionnaire I and (2) completed questionnaire I but not completed questionnaire II.
**not including answered by a friend or relative rather than old people
*** the old people who can not receive an interview because of sickness or deafness or disease.

Concerning the 42% who could not be located, it is possible for the old people to be visiting some other places, or to be living with their children or other relatives temporarily; some old people may have died; a house may be used for a registered address without anyone actually living there; and a registered household may be empty. These situations are more serious in the highly urbanized communities. It shows that the registered household address used for the sampling frame is limited. This is a very important problem which needs to be taken into consideration in future surveys of older persons.

Owing to these factors, the sample actually interviewed showed somewhat different characteristics from the selected sample. As shown in Table 5, the male proportion of the sample of old people interviewed is 4 percentage points higher than those of the selected sample; the proportion of age 65-64 of the sample of old people interviewed is 7 percentage points lower than those of the selected sample; the proportion of age 75-79 of sample old people interviewed is 6 percentage points higher than those of the selected sample. The proportion of sample interviewed in the highly urbanized community is 4 percentage points lower than those of the selected sample; the proportion of sample old people interviewed in the lowly urbanized community is 4 percentage points higher than those of the selected sample. These figures show that the differences between the two samples in sex, age and urbanization level of communities are statistically significant, that is, the proportion of sampled old people interviewed in male, age 75-79 and the low urbanized community, is higher than those of the selected sample.

Table 5
Comparison Between the Selected Sample and the Actually Interviewed Sample

	Sample Selected		Sample Interview		Chi Square Test
	N	%	N	%	
Total	3,042	100.0	1,519	100.0	
Sex					
Male	1,676	55.1	893	58.8	8.35*
Female	1,366	44.9	626	41.2	
Age					
65-69	1,296	42.6	486	32.0	94.90*
70-74	903	29.7	500	32.9	
75-79	391	12.9	286	18.8	
80-84	351	11.9	176	11.6	
85+	101	3.3	71	4.7	
Level of Urbanization					
Taipei City: High	1,276	41.9	575	37.9	14.79*
Taipei Country: High	756	24.9	377	24.8	
Middle	507	16.7	298	19.6	
Low	503	16.5	269	17.7	

Note: * p< .01

In short, the research committee carefully established an adequate sample design and attempted to produce a representative sample of the population. However, the loss of sampled old people twisted the actual sample a little, that is, the actual sample used in the research is more concentrated on male old people, older-old people and the old people living in the low urbanized communities. Therefore, any conclusions and inferences derived from this sample must be viewed with caution.

Questionnaire Construction

This survey attempts to describe the characteristics of a large aging population. In this regard, a carefully selected probability sample was used in combination with a standardized questionnaire. It can offer the possibility of making refined descriptive assertions about old people. The most difficult work for this interdisciplinary study on aging is the development of an integrative instrument. As noted above, our research team was composed of twelve members, but they were mainly interested in their own study topic. In practice, we as a team did not study one topic but twelve topics which belong to various disciplines, for instance, medicine, public health, economics, psychology, sociology and social welfare. For this purpose, a research instrument was not developed from a series of questions about a certain topic but from many kinds of questions about various kinds of topics or disciplines. Therefore, the instrument is was designed to study a field -- the aged, rather than to collect specific information for a topic.

Process of Developing the Questionnaire. The questionnaire was designed to achieve an interdisciplinary integration. First, each member of the research committee was asked to develop his own questions about the proposed topic; secondly, the different questions were integrated into a questionnaire through discussions with each other.

The topics proposed for the survey were: the life of old people; medical treatment; physical and psychological health; family structure; medical care; adjustment of widowed people and their health; economic resources and life-styles; welfare needs and welfare services of old people; aging problems and family structure; property transition between old parents and their children; social roles and personalities; and grandparents' life styles and their relation to grandchildren. The questions produced from this wide range of topics were many and quite diverse.

After having exchanged opinions in the committee, all the questions were classified into four groups: 1) medicine; 2) public health; 3) psychology and 4) socio-economics. The members in each group were asked to examine, revise and arrange the questions referred to them according to the principles of: (1) the questions should be strictly relevant to the survey objectives; (2) the questions which could affect the answers given to subsequent questions should be asked first; and (3) the number of questions for each topic was limited to fifty items. All the questions of the four groups were integrated into a survey questionnaire.

Although our questionnaire was strictly related to the definition of the problems which were going to be tackled by the survey, each of us attempted to cover too much, to ask everything that might turn out to be interesting. As a result, the questionnaire grew from a short list of questions to a document many pages long. In this sense, our questionnaire was not tailored to a client's precise requirements but broadly to deal with the context of life in old age, that is, the total life situation in which old people are thinking, acting and living. It was a comprehensive survey, ultimately.

Contents. The questionnaire was arranged into 25 content subsections, including background data, physical symptoms, family medical history, daily activities, self-reported health conditions, functional limitations, medical behavior, medical treatment, health behavior, family structure, family life, living arrangements, life satisfaction, emotional stability, leisure, social roles, morale, family function, adjustment to pressure, living conditions, attitude toward property, and grandparental role.

These contents can be classified into five broad types of subject matter:

1. demographic characteristics of old people;
2. their physical conditions and health;
3. their social environment;
4. their activities;
5. their opinions and attitudes.

Demographic characteristics refer to such matters as family or household composition, marital status, age, religion and so on. Physical condition and health include daily activity capacity, physical symptoms, disease, medical treatment and family care. In other words, "How is old people's health taken care of?" Social environment covers all the social and economic factors to which old people are subject, including family structure, occupation, income, living conditions, and social amenities. These are subjects which cover, in the widest sense, the question "How do old people live?" "What old people do" refers to their behavior activities, and family relations. Finally, opinions and attitudes deal mainly with property, feelings about later life, and roles.

There were two hundred and twenty-seven questions contained in the five broad types of subject matter in the questionnaire. They were designed to be most appropriate for the respondents. Contingent questions and open-ended questions were used to inquire about the most important things relevant to certain persons and the most sophisticated problems. It is expected that this questionnaire design will minimize the superficiality created by the survey which covered such complex topics. This design inevitably increased the number of questions and time of interview.

Among the 227 items, seventy-five questions had their subquestions or a series of questions about a certain topic. The questions all together formed a long questionnaire. In order to eliminate the effect of a long questionnaire on the morale of both interviewer and respondent, and probably also refusal rates and the quality of the data,the questionnaire was divided into two parts: Questionnaires I and II. Each part was used with the same respondent at a different time. At the same time, each section of the questionnaires was introduced with a short statement concerning its content and purpose, which helps put the interviewer and respondent in the proper frame of mind for asking and answering the questions. As shown in Table 4, the refusal rate was very low. It appears that the negative effect of a long questionnaire on a survey was not significant, in general. It is also evidenced by the low rate of unfinished questionnaires. According to the interviewers' report, only about one percent of respondents were unfriendly. However, the rate of finished Questionnaires II is five percent lower than those of Questionnaire I (see Table 4). In this sense, too many questions in the questionnaire have impacted on the quality of data in Questionnaire II. In short, questionnaire I caused a negative effect on Questionnaire II in data collection.

Field Interview

The field interviewing for collecting data was conducted from January to March 1987. The interviewers were recruited from junior and senior students in the universities in terms of Taiwanese dialect speaking ability. Some of them already had experience in interviewing. Before doing field work, the interviewers received a two-day training program in which they were made familiar with the questions asked in the questionnaire and taught how to interview old people. Field interviews were divided into two periods according to questionnaires I and II. In the first period, Questionnaire I was used. After two weeks, Questionnaire II was used with the same respondents. In other words, each of the respondents was interviewed twice with different questionnaires.

In order to meet the respondents' needs, the interview was conducted in any place where the they could be easily approached; therefore, an interview might have been done in a house or a farm or a gathering place -- e.g., a temple. Interview during the period of twelve to two p.m. were avoided because of an afternoon nap which is an important habit for Chinese old people.

Our field interviews with old people revealed some problems which needed to be considered in this survey research. Generally speaking, the persons living in rural areas tended to accept the interview. But the persons who lived in the apartments of tall buildings in the city showed some reluctance to answer the door; they would not allow interviews until they were sure it was the "right thing."

Educational attainment and living standards were the two most important factors accounting for the different response rates. The old people with higher education easily understood the questions and made smooth communication with interviewers. Similarly, the old people who had a high standard of living tended to have a modern attitude, and they were pleased to talk with interviewers. These two types of old people mostly lived in urban areas. As a result, interviews in urban areas were short and easy, whereas those in rural areas were longer, and it was hard to get precise information.

Socio-economic status also affected the response rates. Although the old people with higher status easily talked to interviewers and answered the questions, they often deviated from directions and talked in a lively manner; sometimes, they even happily showed off on certain questions, particularly regarding income, property, and families. It is very hard for a student interviewer to handle this situation. If an old person's talking is stopped constantly, a pressure would be put on the interview atmosphere. Therefore, maintaining the right atmosphere, and at the same time controlling interview time are important problems for interviewing with old people.

As for the lower status old people, they were not all "workless." Some of them did housework, particularly cooking or child-care; they even worked on a farm. These tasks often forced the interviewer to stop. The intermittent situations undoubtedly affected the interviews.

In addition, old people sometimes had visitors from the neighborhood: peers or relatives. The visitors were very curious about the interview and its questions. This situation happened more often in rural areas. The interviewee might be led to follow these visitors' opinions. Some old people had a hearing problem and needed their children to explain or interpret the questions. The interpreter can be an important factor in the respondent's opinion. Whether visitor or interpreter, it is possible for them to imply something else to the interviewer. This situation imposed a serious problem for the interviewer to handle.

Even though the dialect ability is required for an interviewer, some of them still have a problem of communication with old people, particularly those whose physical and psychological conditions are poor. This situation not only gave the interviewers a great pressure but also lengthened the time of interview.

Except for the long questionnaire which created a psychological pressure, the above-mentioned incidents cost more time, confused the interviewers, and even increased the risks of carrying out a responsibility in a perfunctory manner.

Finally, whether the interviewers can put themselves in the life situation or status of respondents or not is an important problem, because every kind of status has a different expression of language. Because the questions in the questionnaire were written in a literary style, they were not understandable to the uneducated old people.

The morale of interviewers was indeed affected, particularly as revealed in Questionnaire II, in which many questions did not get answers from many old people. Almost 10-15 percent of the sample did not give answers to certain questions.

How the instrument or questionnaire actually worked in the field is a very important problem for the investigator to understand. It is particularly true for this special group of aging population. Certain problems about the instrument emerged.

First, if everything during the interviewing went well, either Questionnaire I or II could be completed within fifty minutes. But this possibility applies only to one-tenth of the sample. The interview for most of the sample needed about an hour. If the interview was interrupted by the respondents' visitors or tasks, it always took an hour-and-a half to complete the interview

Secondly, the language used in the questions was mostly not a spoken language, particularly those in the topics about morale, life satisfaction, emotion and adjustment. This language was hardly applicable to old people with lower status. Chinese Mandarin is quite different from Taiwanese dialect. Both languages can be expressed in the same Chinese character, but their meaning cannot be directly translated into words. They need the interviewer to explain. However, we do not know if their explanation corresponded with the content and purpose of each question

Thirdly, the majority of the questions in the questionnaire were closed-end ones, but their answer categories are quite detailed, even not easily distinguishable. Chinese people are used to describing things or ideas broadly and vaguely; they like to let you know something, but they do not like to speak in too much detail about it. On questions about physical disease or family members, they easily tell you yes or no, but hardly tell you 'what kind of disease or how serious,' or 'What is their education, income or residence.'

Some questions involved quantity; e.g., 'How many times?' 'How much money?' 'How often?' and so on. Except for habitual behavior, old people cannot always precisely remember the figures. It is no good asking old peoples' opinions about events too long ago for them to remember accurately.

They are mostly concerned about the things or events to which they are related. They seem to be more concerned about the present. Therefore, the respondents did not take much interest in answering the questions about topics such as morale, life satisfaction, emotion and adjustment. In these sections of the questionnaires, particularly Questionnaire II, many questions had a nonresponse rate reaching 10 to 15 percent. In short, old people with lower status are more interested in understanding things through intuition or experience, whereas old people with higher status are in a better position to think or appreciate or judge things. As a result, the questions asking opinions and attitudes are more applicable to old people with higher status and living in a highly urbanized community.

An approach of interdisciplinary integration used to investigate the life of old people will a better enable us position to collect data and understand their problems. This approach can produce an enormous sample and develop a comprehensive questionnaire to deal with the total life situation in which old people are thinking and acting. However, the research topics from the various disciplines involve a wide range with different ideas and interests, and thus their integration into a survey questionnaire is a difficult work. It always results in a long questionnaire. Even though the questionnaire can be divided into two parts, part I always affects the quality of data in part II.

During the interviewing, situational factors such as visitors or tasks will disrupt the interview. At the same time, old people tend to talk very much about the interesting questions, and deviate from the direction of the interview. How to maintain an appropriate atmosphere and a proper time for interviewing with old people is an important challenge. Socio-economic status and living standards will affect the response of old people to the interview. Finally, opinion and attitude questions are not applicable to old people with low education and status.

CHAPTER 12

WELFARE POLICIES FOR THE AGED ON BOTH SIDES OF THE TAIWAN STRAIT: A COMPARISON

Wen-Hui Tsai

Introduction

One of the most salient features of the literature on gerontology is that there are obvious and universally recognized differences in the biological endowment and in the psychological, social, and cultural experiences of the elderly around the world. The significance of a cross-cultural comparative study on aging and the aged is well expressed by Donald O. Cowgill in the following passage:

> Institutional and societal responses to [aging and the aged] vary in relation to local conditions and cultural values. Accordingly, there are hundreds of natural social experiments underway in various parts of the world at any given time, experiments in the adaptation of social institutions to changed proportions of the elderly, and individual and group experiments by older people themselves, as they fashion new roles and evolve new solutions to both old and new problems.[1]

It is, therefore, not surprising that in recent years, cross-cultural comparative studies on aging and the aged have gained strength. Although theories of aging and the aged are still heavily built upon the experience of Western industrial societies in general, and of American society in particular, cross-cultural comparison has enlightened us and produced new insights into our own potential.[2]

WELFARE POLICIES FOR THE AGED ON BOTH SIDES OF THE TAIWAN STRAIT: A COMPARISON

During the past few years, studies of the elderly population on both sides of the Taiwan Straits have been popular and quite a few quality works have been produced.[3] The awareness of and interest in Chinese elderly life shown in American gerontology is in part a response to the call for more cross-cultural comparison in the field of gerontology, and in part a response to rapid changes currently under way in these two Chinese societies on the opposite side of the Taiwan Straits that have fascinated many development specialists in the social sciences. In the People's Republic of China (hereafter, PRC) on the Chinese Mainland, we have witnessed the great effort to push Mainland China into a developed age through the campaign for Four Modernizations under the leadership of Deng Xiao-ping. In Taiwan, the Nationalist government has created an economic "miracle" characterized by a rapidly improved national economy, higher per capita income, better income distribution, and political democratization.

Although there are studies of the elderly in the PRC and in Taiwan, no serious attempt has been made to make a comparison between these two Chinese societies. The purpose of this chapter is to examine the demography of the elderly in these two Chinese societies and their respective welfare policies for the elderly. It is hoped to show both differences and similarities between the PRC on the Mainland and the Nationalists on the island of Taiwan.

The Demography of the Elderly

A. *Population Growth*

China now has a population of more than one billion. The 1983 population census shows a total of 1,024,950,000 Chinese living in China. This figure reflects an increase of 483,280,000 persons, or an increase of nearly 90 percent from the population of 1949, which was the year the People's Republic was inaugurated. Such a tremendous increase is the result of the combined effects of a higher birth rate and a lower death rate during the thirty-five years. As we can see in Table 1, with the exception of the two years of 1960 and 1961, the crude birth rate had been exceedingly high prior to the mid-1970's, while at the same time the crude death rate had shown a steady decline during the same period. Events in contemporary China are often dictated by shifts in political and ideological currents, and population policy is no exception.

Until his death in 1976, Mao Zedong was the ruler of the PRC and his thought was the unchallenged socio-political ideology of that time. For many years, "Quotations from Chairman Mao," or the "Little Red Book" as it is known, was the equivalent of the Bible in the Christian world. In regard to population, Mao Zedong believed that the more population China had, the stronger China would be and that it was necessary for China to have more people if it was to successfully resist Western capitalist expansion. Mao took a supply side view and saw population as "human hands" providing working labor, and not as "human mouths" demanding sustenance. In Mao's mind, population was never a problem and, as a result, China's population increased dramatically under his leadership.[4]

Table 1

Population Growth in Mainland China, 1949-1983

Year	Total (thousand)	Birth Rates (0/00)	Death Rates (0/00)	Growth Rates (0/00)
1949	541,670	36.0	20.0	16.0
1950	551,960	37.0	18.0	19.0
1955	614,550	32.6	12.3	20.3
1960	662,070	20.9	25.4	-4.5
1965	725,380	37.9	9.5	28.4
1970	829,920	33.4	7.6	25.8
1975	924,200	23.0	7.3	15.7
1980	987,050	17.0	6.3	10.7
1981	1,000,720	20.9	6.4	14.5
1982	1,015,410	21.1	6.6	14.5
1983	1,024,950	18.6	7.1	11.5

Source: State Statistical Bureau, PRC, *Statistical Yearbook of China, 1984*. Hong Kong: Economic Information & Agency, 1984.

During Mao's era, the Chinese Communist Party rejected outright any attempt to control population growth. The incident of Ma Yinchu, as described in Richard Berstein's From the Center of the Earth, reflected the extreme difficulty of proposing a policy contrary to Mao's belief. In 1957, one of China's leading economists, Ma Yinchu, at the time president of Peking University, proposed at the Fourth Session of the First National People's Congress that a birth-control campaign become part of the mass-education curriculum. Ma, for his pains, was branded a "rightist." He was disgraced and driven from the university and remained for twenty years as an object of official contempt.[5]

Mao's legacy started to fade away, however, in the 1970's and with his death in 1976, so did his pro-natalist view. Population problems finally received greater attention from the government. Communist China's new leaders have decided that the only solution to the problem of poverty and underdevelopment is to step up production and, simultaneously, make population control a state policy. A birth planning program was launched in the early 1970's to slow down China's population growth. This program is generally known as "Wan-Xi-Shao," meaning the postponement of marriage and birth (Wan), the spacing of birth (Xi), and a fewer number of children (Shao). A tougher birth control program was implemented in 1980 by the new leadership under Deng Xiaoping. With this program, each family will be permitted to have only one child. Punishments are given to those who have more than one child.[6] The steady decline of crude birth rates and of natural growth rates shown in the above table reflect the impact of these birth control programs. The Communist Chinese government hopes that, with help from these programs, the Chinese population will not exceed 1.2 billion by the year 2000.

B. *The Elderly Population*

Along with the increase of China's total population, the elderly population has also shown increases, both in number and in proportion to the total population. According to the estimate by the United Nations, the Chinese elderly population aged sixty and over was re ported to be approximately 37,678,000 in 1960, and it had increased to 72,915,000 by 1980. In comparison to the total population, the elderly population's share in 1960 was 5.5 percent and in 1980 was 7.3 percent. It is projected to reach 270,469,000 by the year 2025, which will account for 18.5 percent of the total population. A recent report made available by the Bureau of Statistics showed an even higher estimate that 8 percent of China's population in 1985 was aged 65 and over, and that by the year 2040 this aged population would reach 33 percent of the total population.

Two important factors have contributed to the growth of the elderly population in China. First, a significant decline in birth rates has reduced the size of the younger age group in proportion to the total population. As we have mentioned, the birth rate in the two decades between 1950 and 1970 was extremely high, but it has shown a steady decline since the early 1970s. With the implementation of the one child policy as a means of population control, China's younger age group can be expected to become even smaller in proportion to the total population. Second, death rates have been declining steadily since the mid-1960s, from the highest of 43.4 per thousand in 1963 to the lowest of 18.6 per thousand in 1983 as a result of improvements in the food supply and health care. As people do not die young, the average life expectancy is thus expanded to 66.4 years for males and 69.3 years for females in 1982 and they can be reasonably expected to live even longer in the future.

The increase of the elderly population in China will have at least two significant consequences. First, it will undoubtedly hasten the aging process of the Chinese population. The median age of the Chinese population was 21.0 in 1960; it had increased to 21.7 by 1980, and is expected to be 38.4 by the year of 2025. In other words, nearly half of China's population in 2025 will be nearing forty years of age. Secondly, it will also create a tremendous burden on economically productive age groups. The United Nations' estimate shows that the number of the elderly per 100 workers in China in 1960 was 10 and that the number will be increased to 29 in 2025. In other words, by the year 2025 every three Chinese workers will have to support one elderly person.

Table 2 presents a summary of selected demographic characteristics of the Chinese elderly between 1960 and 2025.

Table 2
Selected Demographic Characteristics of the Chinese Elderly, 1960-2025

	1960	1980	2000	2020	2025
Total Population (in thousands)	667,322	1,002,803	1,255,656	1,428,860	1,460,086
Total Aged Population (in thousands)	37,678	72,815	127,389	234,036	270,469
% of Aged in Total Population	5.6%	7.3%	10.1%	16.4%	18.5%
Median Age	21.0%	21.7%	30.2%	37.7%	38.4%
No. of Aged per 100 Working Age (15-59)	10	13	15	25	25

Sources: United Nations, Dept. of International Economic and Social Affairs, *Periodical on Aging 1:1. 1984; Statistical Yearbook of China, 1984.*

C. *Retirement Benefits for the Elderly*

The increase of the elderly population has prompted the Communist Chinese government to pay more attention to the potential problems facing the elderly. The new Chinese Constitution adopted in 1982 declared that the elderly have the right to receive material assistance from the society and the government, and that the nation has an obligation to provide such assistance through the implementation of such programs as social insurance, social relief, and health care system. Legal protections for the elderly in China include the following:[7]

Constitution: Article 50 stipulates:"Working people have the right of material assistance in old age."

Marriage Law: This statute governs marriage as well as family relations in China, including the rights of elder family members. The General Principles state: "The lawful rights and interests of...the aged are protected." "Within the family, maltreatment and desertion are prohibited."

Article 15 clarifies: "Children have the duty to support and assist their parents." "When children fail to perform the duty of supporting their parents, parents who have lost the ability to work or have difficulties in providing for themselves have the right to demand that their children pay for their support."

Article 18 states: "Parents and children have the right to inherit each other's property."

Article 22 further stipulates: "Grandchildren or maternal grandchildren who have the capacity to bear the relevant costs have the duty to support and assist their grandparents or maternal grandparents whose children are deceased."

The earliest official policy related to elderly welfare under the Communists' rule in China could be dated back to the passage of the Insurance Act in February of 1951, two years after the establishment of the regime, which outlines welfare compensations for the injured, handicapped, the ill, death, birth, dependents, and elderly. The Act established a retirement system for workers in various state and privately owned industries that set the retirement age for men at 60 and for women at 50. Men who have a 25 year work history and have worked 5 years at the current work unit, and women with a 20 year work history and who have worked 5 years at the current work unit, are given a retirement pension between 50 percent and 70 percent of their wages after retirement until their death. The Insurance Act was applied in the beginning only to three major industries of railroad, shipping transportation, and post office. The Act was later extended to include all factories, mining, and transportation industries in 1953. It was further extended to another thirteen industries in 1956. Another important policy was announced by the State Council in December of 1952. The Temporary Implementation Procedures for the Retirees of the Government Offices made the Insurance Act of 1951 available to employees of government offices. Workers of the collectives were included in 1983.

The current pension system for retired workers requires male workers and staff members to retire at age 60, female workers at 50, and female staff members at 55. Mine workers and those who work high above the ground or in extreme heat retire five years earlier. All retirees also are entitled to have free medical care in addition to their pensions. Table 3 details the current Chinese pension system for the retired workers and staff members.

Table 3
China's Pension System

Requirements (for retired workers and staff members)	Pension's Percentage of Former Wages
Those who started work after the founding of People's Republic of China (October 1, 1949):	
a) worked consecutively for more than 10 years but less than 15 years	60%
b) worked consecutively for more than 15 years but less than 20 years	70%
c) worked consecutively for 20 years or more	75%
Those who joined revolutionary work during the period of the Liberation War (on or prior to September 30, 1949)	80%
Those who joined revolutionary work during the period of the anti-Japanese war (on or prior to September 2, 1945)	90%

Source: From Youth to Retirement *(Beijing Review, 1982)*, Table 1, p. 84.

Note: Those who have been honored as National Model Workers, Labor Heroes or Combat Heroes, and those who have made special contributions can receive a pension 5% to 15% higher than the above figures. Cadres who began revolutionary work before July 7, 1937, receive a pension equal to their wages.

As clearly shown in the above table, pensions are a percentage of salary based on the length of time served, work performance and service to the country. Until now, the Chinese wage scale has been built upon a seniority system, i.e., the longer a worker has worked, the higher his/her wage will be. Thus, by the time a worker is ready to retire, he/she has reached a higher wage on the pay scale. It is therefore not surprising that the pension a retired worker receives is not only sufficient to provide him/her a comfortable living, but is also very likely to be higher than the wage his/her adult children receive. A 1983 study on elderly income in Beijing found that the average elderly income from pensions in the city was higher than the income of their children. The retired cadre receives a monthly income of 50.7 People's dollars. This means that the retired cadre's pensions are seventy percent more than the adult children's family income. Higher pensions are also seen in other occupations as well.

We can easily conclude that the life of the retired elderly in urban China is indeed quite comfortable. But one cannot ignore the fact that the great majority of the Chinese population today is still living in rural areas. The situation is the same for the elderly. According to the 1982 census report, 80.87 percent of the Chinese elderly are still living in rural areas, with another 5.17 percent living in townships. Only 13.96 percent of the elderly are living in urban cities. The rural elderly are not covered by the retirement pension system. The great majority of the rural elderly are living with their children. In China today, the traditional filial care system has been put into law, and maltreatment of elderly parents is punishable by law, as discussed earlier. With the growth of the elderly population and the ever increasing financial burden on the government to provide elderly welfare, the government now sees filial care provided by the family members as the best solution to the problems of aging in China for the future and, thus, has started to encourage its citizens to maintain a reciprocal relation between elderly parents and adult children. As one Chinese youth says in a government publication: "Today we enjoy the fruits of the hard labor of our elders. Tomorrow, it is our children's turn."[8] The government wants to advocate filial care for the elderly because it will reduce the economic burden on the government; individuals welcomes it, for it provides both tangible and intangible returns for them.

In addition to the above mentioned state supported elderly welfare programs and filial care from family members, there are other regional and local programs. One of the best known programs is the so-called "five guarantees" program, which now covers approximately 6 percent of the rural elderly. The "five guarantees" include: food (including fuel, cooking utensils, and pocket money), clothing (including bedding), housing (including furniture and home repairs), medical treatment, and burial. The costs are primarily borne by the local communes and brigades, but some state aid is available for poorer places. Senior Citizen Homes can also be found in many places. A study estimates that there are about 9,000 Senior Citizen Homes throughout China that house a total of 138,000 elderly.[9] In general, all residents of a Senior Citizen Home are guaranteed the freedom to enter and leave the home, to move about, to work, and to drink liquor. There are also various programs aimed at helping the elderly to find a companion, enroll in an adult educational program exclusively for the elderly, and to contribute his/her expertise to the work units.

Four Modernization and the Politics of the Retirement System

A. *The Four Modernizations Campaign*

Life in Communist China today is still poor and harsh. During the forty years of its rule on the Chinese mainland, recurrent power struggles, political turmoil, and rigid economic planning have prevented China from achieving economic progress and socio-political stability. Recognizing this economic underdevelopment, Premier Chou Enlai proposed at the Tenth National People's Congress held at Beijing in January, 1975 that, "In this century, we must accomplish the all-out modernization of agriculture, industry, national defense, and science and technology, so that our country's national economy proceeds into the front-row of the world!"[10] Chou's goal was soon to be known as the Four Modernizations and as such has become the slogan of the current administration under the leadership of Deng Xiaoping.

In Deng Xiaoping's vision, China must adopt a twofold policy of opening doors to foreigners and revitalizing its domestic economy to allow per capita income to grow to U.S.$1,000 by the year of 2000. Under Deng's Four Modernizations campaign, China has: (1) opened its domestic market to foreign investments, (2) established special economic zones to provide additional incentives for foreign capitalists, (3) given special tax exemptions to foreign firms established in China, (4) permitted joint business ventures with foreign corporations, (5) sent students to study abroad, (6) abolished the commune system, (7) allowed farmers to grow crops for sale and keep the profits, (8) encouraged private small businesses to flourish in the cities, (9) replaced elderly party leadership in industrial managerial positions with younger and technologically competent new leaders, (10) abolished the life-long guarantee of work in favor of a contractual system, (11) issued a bonus incentive system for urban industrial workers to encourage higher productivity, and (12) allowed the private ownership of property and the cumulation of wealth.

As eighty percent of China's population still lives in rural areas, the restructuring of the rural economy has the most far-reaching effect on Chinese social structure. Rural economic reforms began in 1978 with the establishment of the household responsibility system under which farmers are allowed to sell part of their surplus farm products. The system was aimed at encouraging farmers to increase their productivity. China's rural economic structure was further liberalized in 1985 when state monopolies for purchasing and marketing major farm products were abolished; all products not purchased under state contract were disposed of on the open market. Duan Yingbi, a senior researcher of the Rural Development Research Center under the State Council, said, "The main purpose of the reform...is to readjust the rural economic structure through market regulation, make full use of available manpower and natural resources to move from self-sufficient rural economy to the socialist commodity economy."[11]

The result of this Four Modernizations campaign has been overwhelming so far, as the economy has shown an impressive recovery. According to Chu-yuan Cheng, the annual average growth rate in national income between 1978 and 1984 was 8 percent, in comparison with the growth rate of 6 percent for the period of 1952-1977. Agriculture showed the most impressive growth during the six year period of 1978-1984 with an annual growth rate of 8.2 percent, which was much higher than the 3.2 percent growth rate of the earlier period of 1952-1977. Although China's heavy industry showed a decline, light industry seemed to be promising. Modernization has not only changed China's economic structure, it has also brought changes in non-economic spheres of society as well. We have started to witness an increasing demand in recent years for intellectual and ideological freedom, determined efforts to control population growth, the institutionalization of sending students abroad, increasing geographical and occupational mobility, changes in the top political leadership, the implementation of a tough crime control policy, and the reemergence of such "traditional" cultural practices as religious worship, marriage ceremonies, and archeological preservation. As a result, the overall quality of life in China today has shown some improvements, as illustrated in the Table 4.

Table 4
Major Indicators of Quality of Life
in Mainland China, 1983

Population	
Crude birth rate	18.6
Crude death rate	7.1
Sex composition	Male 51.58% Female 48.42%
Rural-urban distribution	Rural 76.5% Urban 23.5%
Life Expectancy (in 1981)	67.9
Per Capita Income (Renminbi)	458
Education	
% of students in total population	17.96
Number of students per 10,000 persons	
College	11.8
Middle School	454
Elementary School	1,330
% of illiterates in total population	31.90
Health	
Number of Physicians in per 1,000 persons	1.33
Number of hospital beds in per 1,000 persons	2.07
Others	
Units of sewing machines in per 1,000 persons	7.5
Number of bicycles in per 1,000 persons	15.4
Number of radios in per 1,000 persons	20.9
Number of TV sets in per 1,000 persons	3.5

(Source: State Statistical Bureau, *China's Statistical Yearbook, 1984.* Beijing: Zhongguo Tongzi Chubanshe, 1984)

B. *The Retirement of the Elderly Cadres*

Deng's four modernizations campaign is not without problems, however. Resistance from conservative groups has constantly challenged the legitimacy of his reform programs; political corruption has increasingly come to undermine the effectiveness of reform programs, crimes and social unrest have also shown significant increase. In Deng's view, central to the success of his reform campaign is the recruitment of a new group of leadership characterized by youth, education, and professionalism. Consequently, the removal of older cadres becomes inevitable and urgent, for the elderly symbol China's backwardness. Retirement is the only way to get rid of a large number of elderly and seemingly incompetent cadres so that it would allow a younger and often more educated new technocrat group to take charge of the country's move toward modernization. During the past ten years since 1978, a process of politicization of retirement has begun to take shape. A chronological account of statements on retirement and other related matters issued by various government and party establishments in Mainland China since 1978 clearly demonstrates such a process. Table 5 lists important policy announcements and organizational structuring related to retirement and elderly welfare since 1978.

Table 5
The Chronology of Aging Policy in China

June 2, 1978	State Council Temporary Measures on Arrangements for the Aged, Weak, Ill, and Disabled Cadres.
Dec. 29, 1978	Some Views of the Central Organization Department on Strengthening Veteran Cadre Work.
Aug. 13, 1980	Central Committee and State Council Decision to Establish Advisors.
Oct. 7, 1980	State Council Temporary Regulations on Veteran Cadre Special Retirement.
Feb. 20, 1982	Central Committee Decision to Establish a Veteran Cadre Retirement System.
April 10, 1982	Some State Council Regulations on the Veteran Cadre Special Retirement System.
April, 1982	A Veteran Cadre Bureau was set up under the Central Organization Department.
April 24, 1982	The establishment of the Chinese Committee of the World Council on Aging.
May, 1982	The establishment of the Cadre Retirement Division, Veteran Cadre Bureau, Ministry of Labor and Personnel.
Sept. 27, 1982	Central Organization Department, Notice on Establishing Regulations on the Revolutionary Work Before the Founding of the People's Republic of China.
Oct. 30, 1982	Central Organization Department, Notice on Procedures for Veteran Cadres to Process Special Retirement.
Dec. 10, 1982	Ministry of Labor and Personnel, Opinions on Handling Concrete Problems of Implementing "Some State Council Regulations on the Veteran Cadre Special Retirement System".
Oct. 30, 1982	Central Organization Department, Notice on Procedures for Veteran Cadres to Process Special Retirement.
Feb 12, 1983	Central Organization Department, Some Decisions Which Cadres at All Levels Must Observe During Structural Reforms.
April 22, 1983	National Committee on Aging in China was established.
May 16, 1983	Some Answers to Questions about "Opinions on Handling Concrete Problems of Implementing "Some State Council Regulations on the Veteran Cadre Special Retirement System".
Nov. 12, 1985	Notice of the Central Organization Department on Procedures for Cadre Special Retirement.

Several important observations can be made from this table. First of all, policymaking on retirement in officialdom was introduced to resolve an immediate problem: veteran revolutionaries, who monopolized leadership at all levels, had generally low levels of education, expertise, and levels of sheer physical and mental vigor. Retirement was intended to replace old revolutionaries with younger officials better qualified to manage the drive for growth and modernization. Thus, the task of planning and implementation of retirement policy is assigned to the Party's Central Organization Committee as part of a major systematic reform in cadre management. Secondly, as retirement has a strong political overtone, the pension benefits are tied to revolutionary involvement of a cadre. The pension scale is based on the years and periods of involvement in the Communists' revolutionary activities prior to the establishment of the People's Republic of China and in the years served after the revolution. Thirdly, the large number of announcements and orders issued by government and party committees listed in the table also demonstrated that there is a lack of well-designed welfare policy for the elderly. No retirement legislation exists, and all the Communist Chinese policymakers have are pieces of committee directives and announcements that are supposed to serve as guidelines for retirement. Finally, the repetition of several directives and announcements also suggests that there must be strong resistance from the elderly cadres to warrant the party's repeated calls for an orderly retirement from the elderly cadres.

Industrialization and Population Aging in Taiwan, ROC

A. *Patterns of Population Growth*

Taiwan is one of the most densely populated nations in the world. The total 1986 population of 19,454,610 lived in an area of 36,179 square kilometers. The population density in 1986 thus was 537.73 persons per square kilometer, even though the birth rate, death rate, and natural growth rate had all shown a steady decline during the past thirty years. Statistics show that between 1951 and 1986 the birth rate declined from 49.97 to 15.92 per thousand, the death rate from 11.57 to 4.89, and the natural growth rate from 38.40 to 11.03. Two of the factors that have contributed to the high population density in Taiwan are the decline of the infant mortality rate and the increase in life expectancy. As Table 6 shows, the 1951 infant mortality rate of 44.71 per thousand was reduced to 7.64 per thousand in 1986, while during that same period, life expectancy has shown a steady increase, from 53.10 years for males and 56.32 years for females in 1951 to 71.12 years for males and 76.04 years for females in 1986. In other words, the infant survival rate has been greatly improved and life expectancy has gained 23 years for males and 30 years for females.

As expected, the aged have formed an increasingly larger proportion of Taiwan's population, in number as well as in proportion of total population. In Table 6, we find the aged population, defined as persons 65 years old or older, significantly increased from 2.45 percent to 4.41 percent of the total population. If we assign 100 as the base index for the 1951 figures, then the total population in 1981 would have an index of 247.3 while the aged population would have an index of 530.8. It is apparent that the number of the aged is increasing twice as fast as the growth of total population. Taiwan's population is aging and its aged population is expected to reach 18.5 percent by the year 2030. Table 6 gives a summary presentation of Taiwan's demographic facts.

Table 6
Demographic Characteristics of Taiwan, ROC, 1951-1986

Year	Population	Birth Rate (/00)	Death Rate (/00)	Natural Growth Rate	% of 65+ in Total Population	Life Expectancy (Year) Male	Female	Infant Mortality Rate (/00)
1951	7,869,247	49.97	11.57	38.40	2.5	53.1	56.3	44.71
1956	9,390,381	44.84	8.02	36.82	2.4	59.8	65.4	41.55
1961	11,149,139	38.31	6.73	31.58	2.5	62.3	67.7	33.97
1966	12,992,763	32.40	5.45	26.95	2.7	64.1	69.7	21.69
1971	14,994,823	25.64	4.78	20.86	3.0	66.4	71.5	15.51
1976	16,508,190	25.93	4.69	21.24	3.8	68.8	73.7	10.60
1981	18,135,508	22.97	4.83	18.14	4.4	69.7	74.6	8.86
1986	19,454,610	15.92	4.89	11.03	5.3	71.1	76.0	7.56

Sources: Department of Health, Executive Yuan, et. al., *Health Statistics, Vol. 1 General Health Statistics, 1986, ROC,* Table 15, p. 60. Directorate-General of Budget, Accounting and Statistical, Executive Yuan, *Statistical Abstract of the Republic of China, 1983,* and *The Social Indicators of the Republic of China, 1986.*

According to government statistics, 30.58 percent of the aged population were employed in 1981 -- 48.56 percent of the elderly males and 12.51 percent of the elderly females. In that same year, 40 percent of the working elderly were in agriculture, 22.58 percent in service-related professions, 20.97 in business, and 11.29 percent were in manufacturing industries. The educational background of the elderly in 1981 showed that 60.52 percent were illiterate, 21.41 percent had an elementary-school education, 7.11 percent were high-school graduates, and 3.99 percent had a college degree. Analysis of the living arrangements of the elderly in Taiwan shows 86.2 percent living with adult children, 8.0 percent with spouses, and 5.8 percent in institutions.[12]

As both birth and death rates have shown steady declines and life expectancy has shown an increase, the elderly population in Taiwan can be expected to continue to grow. Table 7 shows a projection of the elderly population in Taiwan between 1985 and 2030. It is projected that those aged between 65 and 69 will account for 6.4 percent of the total population and those aged 70 or above will account for an additional 12.1 percent. If we add the two age groups together, then the population share of those age 65 or above will be 18.5 percent. Nearly one in every five persons in Taiwan by that time will be elderly. There is no doubt that such a large elderly population will put a heavy burden on the society's economy. If we compare the aged population with the economically productive age group of those between 15 and 64, the aged dependency ratio in 2030 will be 28.3, but if we define the economically productive age group as consisting of those between 20 and 64, then the dependency ratio will be 31.1 in 2030. In other words, on the average, every three persons in the economically productive age group by that time will have to support one elderly person.

Table 7
Projection of Age Composition of Population in Taiwan, 1985-2030

Age	1985	1990	1995	2000	2010	2020	2030
0-14	29.5%	27.4%	23.9%	22.1%	19.8%	17.8%	16.2%
15-19	9.9	8.9	9.3	8.4	6.8	6.4	5.9
20-64	55.5	57.7	59.6	61.3	63.9	62.7	59.4
65-69	2.1	2.6	3.0	2.9	3.1	5.4	6.4
70+	3.0	3.5	4.3	5.3	6.5	7.7	12.1
Total Population (thousand)	19,258	20,357	21,434	22,384	24,005	24,907	25,097
Independency Ratio							
(65+/15-64)	7.7	9.1	10.6	11.8	13.5	18.9	28.3
(65+/20-64)	9.1	10.5	12.3	13.4	14.9	20.9	31.1

Source: Teh-hsiung Sun, "Concerning Aging Problems," unpublished paper read at the 21st seminar for the Association of Christian Medical Science of the Republic of China, held at Tunghai University, February 13, 1987.

B. *Industrialization and ROC's Welfare Policies for the Aged in Taiwan*

In the eyes of many developmental sociologists and economists, Taiwan is a "hero" of development, for it has lifted itself from abject poverty to a middle-income level in a very short period of time and is now within a decade or so of becoming a fully mature industrial economy. Fei and his colleagues, Galenson and Gold, have all called Taiwan's success a "miracle", whereas Barrett and Whyte have labelled Taiwan "a deviant case" of the dependency theory of development.[13]

Industrialization and economic growth in Taiwan are not an overnight success story. Rather they have been achieved through careful planning and effective implementation of the plans. From 1953 to 1987, seven long-range economic plans were launched and effectively implemented. Unlike economic planning in Communist China through which the state controls all economic activities for production, distribution and consumption, the ROC government encourages the development of private enterprises that allows efficient competition in the international trade market. As a result, the national economy in Taiwan has shifted from agriculture-oriented to industrial-oriented, from import-oriented to export-oriented, and from relative poverty to prosperity. As Table 11-B shows, in 1951 the agriculture share in Taiwan's net domestic product was 35.7%, industry 19.5%, service 44.8%, but in 1987 agriculture had declined to a mere 6.1%, while industry increased to 47.5% and service remained largely unchanged. Such industrialization in Taiwan has created an economic "miracle" characterized by high growth rates and increasing national and personal wealth. Table 8 shows that the annual GNP rate of change during the period between 1951 and 1987 has been extremely impressive, ranging from 11.49 percent in 1987 to 19.78 percent in 1976. The GNP volumes during the same period have increased from U.S.$1,190 million dollars to U.S.$97,534 million dollars. The per capita GNP in 1951 was nearly U.S.$144 dollars and in 1987 was greatly increased to U.S.$4,989 dollars.

Table 8-A
Economic Indicators of Taiwan, 1951-1986 (at current price)

Year	GNP U.S. $ (Million)	Annual Rate of Change (%)	Per Capita GNP (U.S. $)	Per Capita National Income in U.S. $
1951	1,190		144	137
1956	1,381	14.67	141	133
1961	1,740	11.99	151	142
1966	3,134	12.02	236	221
1971	6,553	16.35	441	410
1976	18,318	19.78	1,122	1,039
1981	47,290	18.51	2,632	2,424
1986	73,246	15.59	3,784	3,468
1987	97,534	11.49	4,989	4,573

Table 8-B
Net Domestic Product By Industry or Origin

Year	Agriculture	Industry	Service
1951	35.7%	19.5%	44.8%
1956	31.6	22.4	46.0
1961	131.5	25.0	43.5
1966	26.2	28.8	45.0
1971	14.9	36.9	48.2
1976	13.4	42.7	43.9
1981	8.7	44.6	46.7
1986	6.5	47.1	46.4
1987	6.1	47.5	46.4

Source:*Statistical Abstract of National Income in Taiwan Area, ROC, 1951-1987,* by Directorate-General of Budget, Accounting and Statistics, Executive Yuan, 1988, p. 1 & P. 48.

WELFARE POLICIES FOR THE AGED ON BOTH SIDES OF THE TAIWAN STRAIT: A COMPARISON

As Taiwan becomes an industrialized nation enjoying a greatly improved economy, welfare for the poor, handicapped, and old have begun to receive more attention from both the government and the private sector. One indicator of such a concern is the increase in the government's spending on social welfare throughout the years. Government statistics show that social welfare spending by the government in 1962 was U.S.$27.9 million and was increased to U.S. $2,359.4 million in 1986. The increase of social welfare spending is consistent with the growth in Taiwan's GNP volumes. In 1962, social welfare spending was approximately 1.5 percent of GNP and 7.2 percent of the total government expenditures; it was increased to 3.4 percent and 15.6 percent respectively in 1981. Between 1970 and 1986, five major pieces of welfare legislation were passed: the Welfare Act for Children in 1973, the Welfare Act for the Aged in 1980, the Welfare Act for the Disabled in 1980, the Social Assistance Act in 1980, and the Basic Wage Act for Labor in 1985.[14]

Table 9 gives a historical account of the development of social welfare legislation related to the elderly during the years since the Nationalist government moved to Taiwan in 1949.

Table 9
A Historical Development of Welfare Policies
For the Elderly in Taiwan, ROC, Since 1950

1950	Social Insurance Act for Civil Service Staffs Social Insurance Act for workers
1965	Social policy statement of the Ming-Shen Chiu-I
1968	Social Insurance Act for Workers, Revised.
1969	Social Construction Policy The Ten Year Plan for Taiwan Community Development
1974	Social Insurance Act for Civil Service Staffs, Revised.
1976	Plans to improve social welfare service and social assistance
1978	The Welfare Act for the Aged, Rough Draft passed.
1980	The Welfare Act for the Aged. Implementation Procedures for the Welfare Act for the Aged
1981	Implementation Procedures for the Welfare Act for the Aged, Revised. Standards for the establishment of elderly welfare service agencies.

Among the above welfare legislation enacted in Taiwan, the 1980 Welfare Act for the Aged is the one directly aimed at serving the elderly. A supplementary Act for the Implementation of the Welfare Act for the Aged was passed in the following year, 1981. The enactment of these two elderly welfare acts came as no surprise, as Taiwan in the 1980s has moved beyond the search for economic prosperity and entered a new stage for more extensive social reform aimed at the improvement of the overall quality of life for all sectors of the population in the nation. As the elderly population is expanding, the need for special legislation for the elderly becomes not only unavoidable but also desirable. The Welfare Law for the Aged proclaimed that its main goal was "to publicize and encourage the good virtue of respecting the elderly, to stabilize the elderly livelihood, to maintain good health for the elderly, and to improve welfare service for the elderly".[15] The Act contains 21 clauses in which it outlines responsibility of various government agencies in providing services for the elderly, procedures for the establishing and managing of elderly services by private organizations, and the professionalization of elderly care givers. The Act officially defines the elderly as those individuals aged 70 years old or above. It represents an official recognition of the status of the elderly and the need to provide welfare services for the elderly.

In many ways, the Welfare Act for the Aged has served as a principal guideline in the planning of the welfare services to be provided for the elderly in Taiwan ever since. A preliminary look at the services currently provided for the elderly in Taiwan includes the following:

Retirement pensions for workers, civil service officials and staffs, and military personnel.

Medical care for retirees.

Charity Homes and Homes of the Honorable Veterans.

Monthly allowance for those low-income elderly who remained in their own homes.

Elderly accommodation centers.

Free and half-priced transportation.

Evergreen College for the elderly.

Senior centers and Evergreen Clubs for social and recreational activities.

Social Insurance and supplementary income for the aged.

Free physical checkup.

Homemaker service.

Marriage counselling.[16]

How is the life of the elderly in Taiwan? Table 10 contains five-point scale measurements of the degree of life satisfaction among the elderly in Taiwan. The data are taken from a nationwide attitudinal survey conducted by the government in 1982, with a total sample of 15,282, including 510 elderly people.

Table 10
Life Satisfaction of the Elderly

Item	I	II	III	IV	V
Housing Arrangement	3.5%	24.6%	49.1%	20.0%	2.8%
Work Environment	1.8	21.5	50.9	20.5	5.3
Work Pay	1.6	16.9	53.2	24.4	3.9
Job Security	3.3	20.8	52.0	21.9	2.0
Financial Status	1.0	19.0	51.1	24.2	4.7
Health	5.5	31.3	37.9	22.2	3.1
Community Relationships	9.6	52.9	36.7	0.8	--
Leisure	10.3	41.2	44.7	3.6	0.2

Notes: I Very Satisfied.

II Somewhat satisfied.

III Not one way or another.

IV Unsatisfied.

V Very Satisfied.

Source: Datat compiled from the Survey Report on the Attitufes toward Family Life and Social Environment among the Citizens of Taiwan, 1982: Tables 1,1,1; 1,2,1; 1,3,1; 1,4,1; 1,6,1; 1,7,1; 1,8,1; 2,3,1; 2,4,1.

A clear pattern can be seen from Table 10: the elderly in Taiwan today are enjoying good health, community relations, and leisure. A high percentage of the elderly have rated themselves as either very satisfied or somewhat satisfied with these survey questions. In the area of work, work pay, job security, and financial status, the elderly seem to have a lesser degree of satisfaction, even though more than half express no opinion. The complaint about work and other work-related issues shown here is probably caused by rapid industrialization and a changing occupational structure characterized by automation and youth orientation in Taiwan's newly developed industrial world. Such complaints, thus, are not totally unexpected. Still, if we could take Level III in the above table, those who responded with "no feelings one way or another," then life satisfaction of the elderly in Taiwan is more positive than negative. The same study also asked the elderly to identify the most important factor in making a good life. The elderly responded with good health (70 percent) as the most important, followed by a harmonious family life (17.5 percent), wealth (8.1 percent), a suitable job (1.9 percent) and religion (1.6 percent). The study found that 47 percent of the elderly surveyed preferred to live with their children, in comparison with 43.6 percent indicating a wish to live apart from their children. Only 8.2 percent indicated that they would like welfare agencies to take care of them. In summary, the elderly in Taiwan enjoy a high degree of overall satisfaction in their lives.

Conclusions

Up to now, the PRC model of elderly welfare, characterized by a combination of filial care and state assistance programs, seems to work well. It provides the elderly with financial security and continuous contact with family members. However, the future success of this model will be dependent upon the continued willingness and ability of the family to provide care for the elderly, the availability of housing space allocated to urban workers, a much improved national economy, and continued observation of the traditional respect for the elderly, both in the family and in the larger society.

One fact is clear, though, that the PRC's current campaign for retirement is aimed at a specific group, namely, the elderly cadres, who are viewed by the reform-oriented new leadership as a symbol of China's backwardness and thus an obstacle to China's current push toward modernization.[17] The retirement policy contains a strong political overtone that is designed more for the transformation of political power than for the general welfare of the elderly in the society. As the great majority of China's elderly population reside in rural areas and are not members of the Chinese Communist Party, the current retirement policy will not affect them. There is no doubt that a broader retirement policy designed for the entire elderly population will be introduced in the future once the transformation of power is successfully completed. Until then, retirement is just a temporary tactic in China's continuous saga of power struggle.

In Taiwan, the Nationalist government backed by its newly cumulated national wealth has been more willing to assist the unfortunate members of the society, including the elderly. The Welfare Act for the Aged clearly demonstrates the government's commitment to the well-being of the elderly. In general, the elderly in Taiwan seem to enjoy a satisfactory life; the legislation thus serves more as a general guideline in providing services for the elderly in Taiwan than a step by step procedure for the setup and/or implementation of such services. As a result, many services for the elderly are provided by the private sector of the society, without requesting financial support from the government.

In comparing welfare policies in the PRC on the Chinese Mainland and the Nationalist on Taiwan, one can easily detect a very clear underlying spirit that is common to them; both societies encourage the family to function as the main source of support for the elderly. In Mainland China, more than 80 percent of the Chinese elderly are not covered by the official retirement program, while in Taiwan a large proportion of non-government related professions and business groups are not covered by the retirement pension program. Those who are not covered, therefore, must be dependent upon their family members to provide support.

WELFARE POLICIES FOR THE AGED ON BOTH SIDES OF THE TAIWAN STRAIT: A COMPARISON

Two major differences can be found in welfare policies for the elderly in these two Chinese societies. First, the retirement system in the PRC on the Chinese Mainland has a strong political overtone; it is built upon party membership and years of political service to the party. While in Taiwan, the retirement system is operated more in the spirit of a free capitalist economic style, encouraging and allowing the private sector to manage pension and other benefits for the elderly. Second, although the PRC on the Chinese Mainland promises its citizens equal distribution of national wealth within the spirit of Communism, its economic underdevelopment makes it almost impossible to satisfy the elderly's needs, while in Taiwan, the economic "miracle" which it has achieved during the past 40 years has made it possible to spread its wealth to all sectors of the society, including the elderly. Clearly, political economic differences between these two Chinese societies have created two different systems of elderly welfare programs. In Mainland China, age alone does not determine one's class position or power, party membership does. Thus, age without power could make life difficult. Traditional respect for the elderly is still deep in the mind of many Chinese in both sides of the Taiwan Strait. But rapid social change may make it exceedingly difficult to put it into practice. It will need a good coordinated effort by the government to make it work.

Footnotes

1. Donald O. Cowgill, *Aging Around the World*. Belmont, Calif.: Wadworth, 1986, p. 2.

2. e.g., Walter M. Beattie, Jr., "Economic Security for the Elderly National and International Perspectives." *The Gerontologist 23*: 406-410, 1983. Arnold O. Cowgill and Lowell D. Holmes, eds., *Aging and Modernization.* New York: Appleton-Century-Crofts, 1972. P. Stears, ed., *Old Age in Preindustrial Society.* New York: Holmes & Meier, 1982. J. Sokolovsky, ed., *Growing Old in Different Cultures*. Belmont, Calif.: Wad worth, 1983. John H. Morgan, ed., *Aging in Developing Societies*. Bristol,IN.: Wyndham Press, 1985.

3. Ralph L. Cherry & Scott M. Martinson, "Modernization and the Status of the Aged in China: Decline or Equalization." *The Sociological Quarterly 22* : 253-261, 1981. Steven Harrell, "Growing Old in Rural Taiwan," pp. 193-210 in P. Amoss and S. Harrell, eds., *Other Ways of Growing Old: Anthropological Perspectives.* Stanford: Stanford University Press, 1981. H.Y. Tien, "How China Treats Its Old People," *Asian Profile 5*: 1-7, 1977. Peter Uin and Kwok Hung Lai, "A Reconceptualization of Age Stratification in China," *Journal of Gerontology 38*: 608-616, 1983. (September 30, 1985):6-8.

4. Wen Lang Li, "Policy Implications of Population Dynamics in the PRC," in *Mainland China, Politics, Economics, and Reform*, ed., Yu Ming Shaw (Boulder, Colorado: Westview Press, 1986), 257-275.

5. Richard Bernstein, *From the Center of the Earth* (Boston: Little, Brown, 1982): 50-51.

6. Qin Xinzhong, "China's Population Policy: Theory and Methods," *Studies in Family Planning* (N.Y.), No. 14 (1984):295-310.

7. Su Wenming (ed,), *From Youth to Retirement* (Beijing: Beijing Review, 1982), p 4.

8. Su, *op.cit.*, p. 100.

9. Chiang Cheng-Chang, "Essay on Problems of Aging in Mainland China," *Issues & Studies*, (37:6), 1984: 71-80.

10. Jurgen Domes, *The Government and Politics of the PRC*. Boulder, Colorado: Westview, 1985, pp. 126.

11. Yingbi Duan, "Opening Markets for Rural Products, " *Beijing Review 30,* No. 19, (May 11, 1987):14-17.

12. Executive Yuan, the, *Survey Report on the Attitudes toward Family Life and Social Environment among the Citizens of Taiwan*. Taipei, Taiwan: Research and Development Commission, 1981.

13. For detailed literature reviews on the development of Taiwan's economic miracle, please refer to Wen-hue Tsai, *From Tradition to Modernity, China's Struggle toward Modernization since the Mid-19th Century.* Baltimore: University of Maryland Law School, 1986.

14. Wen-hui Tsai & Ly-yun Chang, "Politics, Ideology, and Social Welfare Programs: A Critical Evaluation of Social Welfare Legislation in Taiwan." Paper presented at the 1982 Joint Meeting of the Evaluation Research Society and Evaluation Network held at Baltimore, MD, October 28-30, 1982.

15. Wen-hui Tsai & Li-chun Hsu, *Sociology of Aging*. Taipei: Chi-liu Books, 1984, pp. 195-205. Also, Michael Hsiao, Ly-yun Chang, & K. C. Chen, *A Study of the Nation's Elderly Welfare*. Taipei: Research and Development Commission of the Executive Yuan, R.O.C. 1981, pp. 120-125.

16. Wen-Hui Tsai, "Modernization and Aging in a Developing Society: The Case of Taiwan," pp. 39-60, in John H. Morgan, ed., *Aging in Developing Societies: A Reader in Third World Gerontology*. Vol. 2 Bristol, IN.: Wyndham Hall Press, 1985. Also Hsiu-hsiung Bai, "Welfare Needs and Services of the Aged in Taiwan Area, ROC", Unpublished paper read at the 1987 Annual conference of the American Association for Chinese Studies, held at Washington, D.C., October 24-25, 1987.

17. Wen-hui, "Life After Retirement: Elderly Welfare in China," *Asian Survey* (27:5), May 1987: 566-576. Wen-hui Tsai, "From Old to Young: The Retirement Life of Chinese Communist Cadres and Its Political Implications," *Issues & Studies*, *23*: 9 (Sept. 1987) 42-57.

CHAPTER 13

THE COPING BEHAVIOR OF CAREGIVERS IN HONG KONG: A PRELIMINARY REPORT

Alex Y.H. Kwan

More than thirty years ago, Western gerontologists began to call attention to the importance of families in the lives of the elderly (Schorr, 1960; Streib, 1958). The increasing concern about planning for long-term care of the aged in the community has led to the rediscovery of their natural supports -- family, friends and neighbors. Although the aged have traditionally been cared for by this informal network, until the mid 1970s few social services were designed to meet their needs (Zimmer, 1983). It was not until the research studies of Cantor (1975), Hagestad (1981) and Shanas (1979 and 1980) dispelled the myth of the abandoned aged that we began to systematically examine the nature and extent of care provided by the natural supports.

Informal welfare, or the meeting of social needs through physical or material help and/or emotional or cognitive support provided by relatives, friends and neighbors has in the last decade become a well-established area of study, at least in the major English-speaking countries, particularly Britain and the United States. Gerontological research has shown that the vast majority of older Americans have living relatives and are in contact with them frequently, tend to live near their adult children, exchange mutual aid, and report concern and positive feelings for each other (Atchley, Miller, & Troll, 1979.) Adult children have been found to be intensely involved in helping their parents cope with a wide range of problems (Simos, 1973), and to provide extensive assistance to them at substantial sacrifice and strain (Monk, 1979).

THE COPING BEHAVIOR OF CAREGIVERS IN HONG KONG: A PRELIMINARY REPORT

The increasing proportion of elderly in the U.S. and the problems associated with caring for them are well-documented (e.g., Cantor, 1983). This chapter is designed to be an illustrative, rather than an exhaustive, review of the literature on family support for the impaired elderly. Fortunately, several recent works provide a comprehensive review of the work in this area (e.g., Antonucci & Kahn, 1980; Atchley, Miller, Troll, 1979; Bengtson & Treas, 1980; Fischer & Hoffman, 1985; Fogel, Hatfield, Kiesler, Shanas, 1981). The fastest growing subgroup of the population are those who have the poorest health, who need the most care, and who are the least financially able to pay for that care. Given these circumstances, it is not surprising that the families of the elderly provide approximately 80% of all home health care (National Center for Health Statistics, 1978).

In most developing nations, the support of the elderly remains a family responsibility, and the great majority of older people live with an adult child or other relatives. Just as the dominant myth about family life in the U.S. -- that adult children no longer provide as much help to parents as they did in the good old days -- began to be scrutinized by gerontologists in the mid-1960's (Brody, 1985), gerontologists in developing nations are now challenging the notion that all families are able to provide good care to older relatives in the face of rapid social and demographic changes. These changes are occurring in developing nations at a much faster pace than they did historically in the developed world (Gibson, 1985).

In modern Hong Kong, long life seems to be a mixed blessing. According to census statistics (Census and Statistics Department, 1986), the number of people aged 60 and over was estimated to be 640,100 in mid-1986 (11.6% of the population) and is expected to rise to 737,100 in mid-1990 (12.6% of the population). Aging in contemporary Hong Kong is fraught with insecurity -- a situation likely to persist for quite some time (Ikels, 1980). For a period of 20 months between 1973 and 1976, Ikels (1983) contacted 99 individuals over the age of 60 from whom she was able to obtain extensive information or residence patterns. The study illustrated well the kinds of strain that long-term care can place on the family. In the absence of extended kin or neighborly ties, the family gets little respite from the constant attendance such a person may require. Not surprisingly, many old people live in dread of becoming such burdens.

Looking at the present and into the future, it seems that the family is and will continue to be a viable social unit for the care and protection of the elderly. However, the extent to which the family is able to assume responsibility in terms of economic, social, and emotional support would very much depend on the effort of the government to strengthen the capacities and resources of the elderly and the family (Tam, 1982). As further suggested by Tam (1982), the basic realities of the situation are clouded because of the lack of coherence in community planning, which is reinforced by the absence of a structure broad enough to comprehend the problem.

Although the family in Hong Kong is still performing an important function in caring for its elderly members, its effectiveness is rapidly declining (Chow, 1988). The caregiving process is indeed complex. Some clarification and understanding can be gained by addressing the following questions: What problems are experienced most frequently by spouse caregivers? How do they cope with these problems? What techniques do they find most effective? How can we identify people with poor coping skills? Do different kinds of people cope differently with the same problems? How influential are family adaptability and cohesion, motivation of caregivers, memory and behavior problems, caregiver strain, burden, and social support on the elderly's coping behavior and its effectiveness? Are there any relationships among all the above independent variables?

Method

Sample

The findings reported here stem from data collected for a study that was used to assess the coping behavior of elderly caregivers in Hong Kong which was financially supported by the Research and Outside Practice Committee of City Polytechnic of Hong Kong. The sample consisted of identified family members drawn from the Family Services Centre, Home Help Team, Social Centre for Elderly, and Multi-Service Centre for the Elderly in the Hong Kong community in November, 1987. The sample caregivers had at least: (a) to be willing to be interviewed, (b) to consider themselves to be the primary persons providing assistance to their older relatives; (c) 55 years old; and (d) to have been providing care for at least three months. The demographic characteristics of the sample are presented in Table 1. The majority of the sample consisted of spouses (38.9%); the remaining 28.7% of the sample consisted of adult children and 8.3% relatives. Over two-third of the caregivers had at least a primary educational background (53.5%). About half of the caregivers themselves were old persons (54.1%); only 45.9% were aged 59 or less. Only 24.8% of the caregivers' occupations were unclassified; 26.1% were employed in the production field, 17.8% in the servicing field, and 14% in the professional field. The sample respondents were predominantly living in public housing (63.1%).

The demographic characteristics of the elderly being cared for are presented in Table 2. Nearly 62% of the elderly were beyond 75 years of age. Over half (51%) of them were illiterate. One third of them were housewives (36.9%), 21.7% were employed in production, and 15.9% were in services. Most of their major illnesses were related to the circulatory system (16.2%). The majority of the elderly (60.5%) reported that they had no chance of being admitted to a care-and-attention home in the next year. Also, 34.4% of the elderly had an annual income of less that HK$5,000 dollars. Most of them had been married once (61.1%) and 13.4% had been married more than one time. Many of them (40.1%) were without any religious beliefs. Only 20.4% of the elderly were receiving supports from children; 61.8% were all by themselves.

Table 1
Demographic Characteristics of Caregivers

Characteristics	N	%
Age		
Adults (59 or under)	72	45.9
Young old (60 - 74)	56	35.6
Old old (74 - 84)	23	14.7
Very old old (85+)	6	3.8
Education		
No education	39	22.9
Private tutorial	19	12.1
Primary	48	30.6
Secondary	36	22.9
Occupation		
Professional	22	14.0
Production	41	26.1
Servicing	28	17.8
Unclassified (housewife)	39	24.8
Relationship to care receiver		
Husband/wife	61	38.9
Children	45	28.7
Relative	13	8.3
Type of Housing		
Public housing	99	36.3
Private flat	37	23.6
Room	13	8.3

Table 2
Demographic Characteristics of Care Receivers

Characteristics	N	%
Age		
Young old (60 - 74)	57	36.3
Old old (75 - 84)	61	38.9
Very old old (85+)	36	22.9
Education		
No education	80	51.0
Private tutorial	28	17.8
Primary	27	17.2
Secondary	12	7.6
Occupation		
Unclassified (housewife)	58	36.9
Production	34	21.7
Service	25	15.9
Major Illness		
Circulatory system	49	31.2
Locomotive system	33	21.0
Nervous system	16	10.2
Chance admitted into C & A home in next year		
0%	95	60.5
25%	18	11.5
50%	21	13.4
99%	20	12.7
Annual income		
Less than HK$5,000	54	34.4
Number of children supporting		
None	97	61.8
One	19	12.1
Two	13	8.3
Religion		
No religion	63	40.1
Buddhist	31	19.7
Protestant	23	14.6
Catholic	10	6.4
First marriage		
Yes	96	61.1
No	21	13.4

Measures

Within the study, seven measures were used to tap the necessary information from the caregivers. A total of 157 successful interviews were obtained. The Coping Inventory (CI) presented 34 specific problems in six areas: care management, personal/psychological, interpersonal with spouse, interpersonal with others, financial, and other situations. If a respondent reported experiencing a particular problem, the inventory provided an opportunity to describe the coping response used in an open-ended format. The respondent then evaluated the effectiveness of that coping technique using a five-point Likert scale. The other measuring instruments included Motivation of Caregivers (MC) with 9 questions; the Memory and Behavior Problem Checklist (MBPC) with 28 questions; the Caregiver Strain Index (CSI) with 13 questions; the Burden Scale (BS) with 29 questions; the Family Adaptability and Cohesion (FAC) with 20 questions; and the Social Support Inventory (SSI) with 25 questions. Most of the questions were in the Likert Scale format. Following the collection of the data, they were put into the DG system, using SPSSX for data analysis.

Preliminary Results on Measurement

Data were analyzed according to the following stages -- first, univariate analysis for a general profile of the respondents and, secondly, bivariate and multivariable analysis (e.g., reliability test, stepwise regression analysis, factor analysis, ANOVA) were applied to identify statistically significant relationships. To test the reliability of the eight measurements, the Guttman split-half method was used and reliability coefficients were calculated. Table 3 presents the results of the reliability test. Relatively speaking, most of the measuring instruments were rather reliable. It is expected that further analysis will be completed in the near future and presented in a study report.

Table 3
Guttman Split-Half Reliability Coefficients of Measurements

Measurements	Number of items	Reliability Coefficients
Motivation of Caregivers(MC)	9	.72
Family Adaptability and Cohesion (FAC)	20	.98
Social Support Inventory (SSI)	25	.96
Memory & Behavior Problems Checklist (MBPC)	29	.75
Caregiver Strain Index (CSI)	13	.84
Burden Scale (BS)	29	.86
Coping Inventory	33	.87
Effectiveness of Coping (EC)	33	.69

References

Bengtson, V.L. & Treas, L. (1980). The changing family context of mental health and aging. In J.E. Birren & R.B. Sloane (Eds.), *Handbook of Mental Health and Aging,* (p.400). N.J. : Prentice-Hall.

Brody, E.M. (1985). Parent care as a normative family stress. *The Gerontologist, 25,* 1.

Cantor, M.H. (1975). Life space and the social support system of the inner city elderly of New York City. *The Gerontologist, 15,* 23-27.

Cantor, M.H. (1983). Strain among caregivers: A study of experience in the United States. *The Gerontologist, 23,* 597-604.

Census and Statistics Department. (1986). *Hong Kong 1986 By Census: Summary Results*. H.K.: Government Printer.

Chow, N.W.S. (1988). Aging in Hong Kong. Unpublished paper.

Fischer, L.R. & Hoffman, C. (1985). Who cares for the elderly: The dilemma of family support. In M. Lewis & J. Miller (Eds.), Social problems and public policy. CT.: JAI Press.

Fogel, R.W., Hatfield, E., Kiesler, S.B. & Shanas, E. (1981). (Eds.), *Aging: Stability and Change in the Family*. N.Y.: Academic Press.

Gibson, M.J. (1985). Caregiving in the Third World. Paper presented at the Virginia Little Memorial Symposium, Social Care: A National & International Perspective. The Annual Meeting of the Gerontological Society of America, New Orleans, November 24.

Hagestad, G.O. (1981). Parent and child: Generations in the family. In T. Field (Ed.), *Human Development*. N.Y.: Wiley.

Ikels, C. (1980). The coming of age in Chinese Society: Traditional patterns and contemporary Hong Kong. In C.L. Fry (Ed.), *Aging in culture and society*, (pp.80-100). N.Y.: Praeger.

Ikels, C. (1983). Aging and adaptation: Chinese in Hong Kong and the United States. Connecticut: Archon Book.

Kahn, R.L. & Antonnuci, T.C. (1980). Convoys across the life course: Attachment, roles, and social support. In P.B. Baltes & O.G. Brim, Jr. (Eds.), *Life-span Development and Behavior*, Vol. 3. N.Y.: Academic Press.

Monk, A. (1979). Family supports in old age. *Social Work, 24*, 533-539.

National Center for Health Statistics. (1978). *Current estimates from the health interview survey*, (Series 10, No. 126). Washington, D.C.: United States Government Printing Office.

Schorr, A. (1960). *Filial responsibility in the modern American family*. Washington, D.C.: Social Security Administration.

Shanas, E. (1979). Social myth as hypotheses: The case of family relations of old people. *The Gerontologist, 19*, 3-9.

Shanas, E. (1980). The family as a social support system in old age. Paper presented at the Symposium on Natural Support Systems for the Elderly, 30th Annual Meeting of the Gerontological Society, San Francisco.

Simos, B.G. (1973). Adult children and their aging parents. *Social Work, 18,* 78-85.

Streib, G. (1958). Family patterns in Retirement. *Journal of Social Issues, 14,* 46-60.

Tam, T.S. (1982). A report on the problems of the elderly in Hong Kong. In *Proceedings: The Elderly of Asia,* Asian Regional Conference on Active Aging, January 24-28, Manila. (pp. 247-264). Manila: Social Research Center, University of Santo Tomas.

Troll, L.E., Miller, S.J. & Atchley, R.C. (1979). *Families in Later Life.*

Zimmer, A.H. (1983). Community care for the aged: The natural supports program. In G.S. Getzel & M.J. Mellor (Eds.), *Gerontological social work practice in long-term care.* (pp. 149-155). N.Y.: Haworth Press.

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CHAPTER 14

SEGREGATED HOUSING AND RESIDENTIAL SERVICES FOR THE CHINESE ELDERLY IN HONG KONG

Raymond Ngan

Introduction

The debate on whether housing services for the elderly should be provided in the form of age-segregated or age-integrated types has been going on for a long time. The age-segregated perspective holds that age-homogeneity tends to yield the larger number of friendships and takes a rather pessimistic view that efforts to integrate various age groups may induce isolation among older persons.

However, in an era which talks about community care, age-segregation of older persons appears to run counter to the caring policy. Furthermore, to the extent that the negative attitudes toward old age are related to the notion of a "dying community of frail elderly, " age-segregation appears dysfunctional and also unfair to our senior citizens.

Contrary to the adopted official policy of "care in the community," nearly all the different types of residential care services for the elderly in Hong Kong have been developed in age-segregated forms. They remain homes for the aged. Although some of the hostels have been built in urban public housing estates, there have scarcely been any attempts to promote intergenerational interaction and visits in the communities where they are located. As a result, they remain "in the community" but segregated from the rest of the population. It appears to me that this is only community care in a physical sense, and not in the sense of "care by the community" (Bayley, 1973, 1981).

It is the intent of this chapter to examine whether age-segregated housing and residential services are addressing the needs and promoting the mental health of elderly people. If not, it must be asked: What pragmatic modifications are needed to redress the situation? This analysis is not just confined to Hong Kong, but also focuses on Singapore which has more elderly in the form of age-integrated housing of the family unit. The modified extended family can still, therefore, be functional and supportive to our elderly people in urban and industrialised countries.

The Meaning of Housing for the Elderly

Bearing in mind the physical degeneration of elderly people, adequate housing takes on a particular importance for them. They want more than shelter. They desire a "home" and living environment that can satisfy their special needs and enhance the quality of their lives (Yelaja, 1978). The physical and social housing environment must be designed to support normal human activity and interaction without lessening independence or causing isolation of the individual (Jordan, 1984). A recent study by Dianne Willcocks on British local authorities old people's homes found the following discouraging phenomenon:

> In reality, the ideal of providing a 'homely' setting is a genteel facade behind which institutional patterns, not domestic ones, persist. . . . . Organic links are rare and community integration generally remains no more than a reflection of locality, the home being 'in' but not 'of' the community (Willcocks, 1987).

The reasons leading to the above phenomenon are that such aged homes, in their outlook, have been characterized by their enclosed and private nature, since they shelter only people of similar generations and there have been few attempts to promote interaction and social links with the communities where the homes are located. They have overlooked the metaphysical dimension of the concept of home, which is the meaning and significance ascribed by individuals and communities to home (Downs & Stea, 1973). To be integrated fully into the community, old people's homes should be accepted by and interact with the community at large.

The second important concern relates to the availability and affordability of the types of housing alternatives for elderly people. The alternatives must be consistent with a variety of styles and with a variety of physical health levels of elderly people who can have quite different sets of needs. Apart from that, they should have a range of housing options from which to choose at a price that they can afford to pay. In Hong Kong, there is a variety of government-subvented residential establishments for elderly people run by the voluntary welfare agencies; namely, hostels, homes, infirmaries, care and attention homes. However, all of these are in acute short supply and have long waiting lists. For instance, it takes at least from five to seven years for an old man to be admitted to a care and attention home in Hong Kong. Since the supply of residential establishments is insufficient, the choices available to elderly people appear illusionary.

As to affordability, the lack of a Central Provident Fund Scheme in Hong Kong further aggravates the situation since most elderly people retire without any pension. Unless elderly people are living together with their family or have enough savings or are civil servant pensioners, the last resort to turn to is the subvented residential establishment, since the charges for private nursing homes for the elderly are very expensive. Without secure financial support, elderly people in Hong Kong can have little say in the choice of the type of residential and housing establishments they prefer. The choice is dictated by low price and cheap rent and by how long one has been on the waiting list for those homes subvented by the government.

The Housing Debate: Age-Segregated Versus Age-Integrated Housing

Closely related to the choice of housing alternatives for the elderly is the issue of whether they should be in the form of age-segregated or age-integrated housing. It is becoming much more controversial nowadays when the prevailing emphasis is on community care. However, the terms "segregation" and "integration" are usually left undefined, so that much of the debate lacks any very solid grounding.

In this context, I would like to use the definition adopted by Shanas (1968) who defined "integration" as the extent to which an individual is knitted into the social structure. Consequently, its extreme relativity becomes apparent for "segregation". In the context of housing design, age-integrated housing means that the elderly person lives with other age groups in age-mixed types of housing in the community, whereas age-segregated housing is usually a specially designed housing service for the elderly living together in a homogeneous age group such as retirement communities and residential institutions for the elderly.

"Age-segregated" gerontologists believe that age-segregated communities do offer more likelihood of services and greater chances for social support. In a homogeneous community, the aged mainly interact with people who share a common history and common age concerns so that they have a greater potential for congenial personal relationships and can develop effective informal social support networks (Hochschild, 1973; Lawton, 1975; Pastalan, 1983). Stephen Golant even goes one step further by alleging that these homogeneous support networks can deal with death better because "the elderly people can talk to each other and can accept with greater equanimity the inevitability of their own death" (Golant, 1985).

However, my research on attitudes towards death and dying among the elderly in Hong Kong in 1985 found that 69.4 percent of the respondents living in age-mixed types of housing had never talked with anyone about death and dying since they believe that this is an unpleasant topic to talk about, especially in the context of a face-saving Chinese culture.

Montgomery (1977) concludes that age-segregated housing tends to increase the number of friends and the extent of social interaction, to improve morale, and to contribute to a normative system in which elderly people are spared competition and possibly conflict with the lifestyles of the young. He has his support from an earlier study by Irving Rosow in 1966 who suggested that friendship patterns varied in direct proportion to the number of aged peers living nearby -- age-homogeneity yielded the larger number of friendships (Rosow, 1966).

If the picture is so rosy and supportive, then why do quarrels and fights still occur among the residents in homes for the aged? A recent study by Deborah Race in 1982 on residential and institutional services for the elderly in Hong Kong found that although living in an age-homogeneous environment, over-half (58.9%) of the inmates did in fact keep their problems to themselves and felt that no one turned to them in difficult times. Only 7.8 percent really shared their problems with their roommates.

The above findings tell us that although living in an age-homogeneous environment, elderly people are probably not inclined to discuss their problems with their fellow residents. This is particularly so when we take note of the fact that the Chinese are a face-saving ethnic group -- to have one's own problems being spread around is to lose face and may be shameful to one's personal pride (Li and Yang, 1971).

As to the preparation for death and dying in age-segregated settings, Lewis Mumford takes a pessimistic view:

> When the bell tolled, it tolled not only for the departed;
> it ominously summoned those who were left . . . . . All
> we do here is to wait for each other to die."
> (Mumford, 1956)

Instead of giving a supportive ventilation, living together with frail and dying elderly people could possibly worry the old folks that the passage to the graveyard is drawing uncomfortably nearer.

A few gerontologists still believe that older persons living in age-segregated housing can give better access to social services, both because of greater ease of delivery of public programmes and because neighbours of their own age who understand and sympathize with their needs will be of more help than those in multigenerational communities (Butler, Oldman and Wright, 1979; Golant, 1985).

In Hong Kong, there is no over-provision of services. Rather, the reverse is usually the real pattern -- old people move in first to the 'Special Quota Grant' public housing scheme in new towns, and supportive social services like multi-service centres for the elderly develop much later. This special-quota housing scheme operates on the policy that three related or unrelated elderly people can apply together and be granted a rental unit in public housing within two years.

As to the help available from a homogeneous age group of neighbours, this seems possible in the early years of the age-segregated environment provided that the neighbours are supportive, sympathetic and able-bodied. However, ten years later, when all become senile, fragile and physically incapable of rendering help, then these segregated housing schemes may eventually become geriatric ghettos.

The Development of Housing Services for the Chinese Elderly in Hong Kong

In Hong Kong, the first and the only Programme Plan for the Elderly was drawn up in 1977. The concept of "care in the community" remains the central guiding principle. The emphasis is:

> to promote the well-being of the elderly in all aspects of their living by providing services that will enable them to remain members of the community for as long as possible; and to the extent necessary, to provide residential care suited to the varying needs of the elderly (Programme Plan, 1977).

Long-term residential care should only be considered as a last resort when there is no satisfactory alternative. This is because the Hong Kong Government believes that the adequate provision of suitable housing for the elderly will not only reduce the demand for institutional care, but will enable more elderly people to stay in the community in accordance with the objective of "care in the community".

According to a sample study of cases on the Social Welfare Department waiting list for admission to hostels for the aged in October 1980, accommodation problems rather than family relationship problems were the major reason given by 54.6 percent of those seeking admission to a hostel. Judged in this light, it is understandable that since 1979, the Housing Authority has set up a quota of housing for the elderly to speed up the availability of public housing services to the aged in need. As already noted, the idea was to house three elderly persons, related or unrelated, in a rental flat within two years of their application. To start with, 300 flats were set aside for about 1,000 elderly people. This quota was increased to 400 for the year 1982/83 for 1,200 elderly persons.

At first sight, this policy should be welcomed as it did speed up the provision of rental public housing units for the elderly. Up to June, 1985, 6,700 elderly were housed under this scheme throughout Hong Kong's 117 housing estates (Housing Authority Annual Report, 1986).

Although proponents of this quota housing scheme believe that small groups of elderly people could live harmoniously and independently in their own rental flats on public housing estates, empirical experiences are proving the opposite. A study by the Housing Department in 1986 found that at least 14 percent of these residents had quarrels with their roommates, which 8 percent were frequent quarreling *(The Oriental Daily News,* 17.8.1986). Furthermore, 27 percent of them would like to move to hostels for single people to avoid further quarrels.

Another study by Alex Kwan (1985) revealed that instead of a communal spirit, there was intense rivalry and very little in the way of social services provided for residents in quota housing. Most people do not qualify for a place in estate social centres that cater to the elderly because these centres already have very long waiting lists. In one case, a stroke has prevented a man from leaving his flat for the past 5 years. Even the study by the Housing Authority has confirmed that at least 14 percent of these residents have perpetual illnesses. Reduction in social interaction is also evident. The study by Esther Chow (1983) found that 74.2 percent of the residents in quota housing did not see their friends very often.

The main problem in this type of housing scheme is that the policy of allowing three unrelated elderly people to live in one single room really poses fundamental problems for living. Esther Chow's study found that 32.4 percent of the respondents complained about the incompatibility of the lifestyle and habits of their housemates in daily living, and 54.2 percent of them claimed that they had experienced conflicts and arguments among themselves (Chow, 1983). Age-homogeneous housing for unrelated persons living under the same roof really poses questions for co-living.

Since 1987, the Housing Authority has launched the Sheltered Housing Scheme for the elderly. Though still keeping to the policy of three unrelated persons residing together in one rental flat, it is specially designed to allow a independent water, gas and electricity supply, independent television and radio socket, telephone line, and cooking bench and sink for each of the housemates. So that in the same flat, three separate facilities are being installed for the above utilities so that disputes over their use can be avoided. The only things housemates have to share are the toilet and laundry facilities. At a policy level, the Housing Department is committed to run one sheltered housing area for elderly people for every 3,000 public housing units for old people capable of self-care. My concern is that in ten years' time, a considerable number of the residents there will have deteriorated physically --- and by then they would experience problems in self-care. Furthermore, wardens of these sheltered housing schemes are only secondary school leavers, without any training in social work. Their qualifications in managing sheltered housing are in doubt, especially in the handling of possible quarrels and relationship problems among roommates.

In designing housing for the elderly one cannot, and should not, just give them housing and forget about other basic needs like medical and supportive social services. If the flats represent little more than places to sleep, they are "shelters" and not home. The development of public housing services for the elderly in Hong Kong has overlooked the need for integrative planning with the relevant government departments in order to build up a coordinating and sufficient network of community support social and medical services for elderly residents. This is particularly necessary if we take a long-term and developmental perspective, bearing in mind the longer life expectancies and the physical degeneration of elderly people after years of living in these self-contained age-homogeneous living flats.

The Development of Residential Services for the Elderly in Hong Kong

The concept of "care in the community" does not obviate the need for institutional services for a proportion of the elderly population in need in Hong Kong. When care in the community is no longer viable or satisfactory because of increasing fragility, institutional facilities will be restricted to those elderly persons who, even with help, are unable to live in homes of their own but are not in need of continuous medical or nursing care.

In Hong Kong, we have a diversity of residential institutions for the aged; namely, hostels, homes, and care and attention homes. Hostels accept able-bodied elderly people capable of self-care. No meal service is provided. However, after years of operation, it has been found that a meal section is needed for those inmates whose health deteriorates with advancing age.

Usually these hostels are located in public housing estates but there have been few attempts to promote intergenerational visits and interaction, on a perpetual and regular basis, in their locating communities. In some public housing estates, although downstairs there are social centers for the elderly, the inmates in hostels cannot register as members since these centres are for the elderly in the community and not for those living in hostels.

Homes for the aged provide centralized meals service, heavy laundry and daily cleaning. Residents admitted are those who are capable of personal hygiene, though they have difficulties in managing chores such as cooking and laundry. However, a common problem faced by such existing homes in Hong Kong is the difficulty in looking after some residents who, though mobile and in relatively good health on admission, subsequently deteriorate to the extent where they require nursing or more intensive personal care than the home provides. Transferring them to care and attention homes proves difficult, as such homes are quite few in Hong Kong.

In fact, the same problem of transfer is also being faced by care and attention homes which, by establishment, accept old people with a need for limited nursing care of not more than two and a half hours a week but which eventually get stuffed with people who require much more nursing and medical care due to the further physical and functional deterioration of the residents. As a policy, the latter should be transferred to infirmaries. In reality, infirmaries are extremely rare in Hong Kong.

According to the existing government planning ratio, the current demand should be 2,554 beds but the actual provision is only 1,040 beds in March 1986. The shortfall is 1,514 beds so that, in actual practice, elderly patients who require infirmary care may be uneconomically put in acute hospital beds or be forced to return to their families who neither have the skills nor facilities to care for them in a proper manner.

In retrospect, residential services for the elderly in Hong Kong suffer from a fundamental defect in planning -- service types are being compartmentalized in separate institutions according to the frail conditions of the elderly. Bottlenecks and deadlocks take place when the relevant transfer institutional beds are in acute shortage. Worse still, even if transfer is possible, the elderly person in question experiences dislocation when moving into a totally different and new institution, prompting his or her further physical deterioration.

To redress the situation, the government announced in early 1988 that the best solution is to have mixed types of residential institutions for the aged in Hong Kong. The idea is to include limited care-and-attention units in institutions in public housing which already have hostel and home sections. By so doing, the elderly will not need to be dislocated and compartmentalized in separate institutions. While this policy measure should be welcomed as a major breakthrough in residential care for the elderly, the planning ratio for these mixed types of institutions should be worked out early and realistically.

Singapore: Policies in Support of Family Care for the Elderly

Since the great majority of elderly people are living with their families in the community, so long as positive housing measures have been devised to support the family institution to care for the aged, the debate on age-segregated or age-integrated housing would appear secondary for most elderly people.

In the 1970s, the Singapore Government noted that more and more young citizens were choosing to live apart from their parents after marriage. This was taken as a sign that the younger generation would be less willing and able to care for their elderly parents in the way the Asian extended family was traditionally known to care for its old folks.

In an attempt to preserve the extended family system, the Housing Development Board introduced the Joint Balloting Scheme, the Mutual Exchange of Flats Scheme and the Reside Near Parents Married Children Scheme to enable family members to reside close to one another, and the Multi-Tier Family Housing Scheme to encourage multigeneration families to live in the same dwelling unit so as to promote family care of the elderly.

The Joint Balloting Scheme, introduced in 1978, enables parents and married children to be allocated flats next door to each other, within the same block or in neighbouring blocks within the same ballot exercise. Priority is given to the parents-and-married children combination since the aim of this scheme is to promote this form of family living and social care. As of March 1985, there were 7,000 joint balloting selection groups involving 14,700 families that have benefited from this scheme and 993 more groups are on the waiting list (Housing Development Board, 1987). The popularity of the scheme is quite evident.

In comparison, the Mutual Exchange of Flats Scheme is less popular. This scheme allows any Housing Development Board (HDB) lessee who has occupied his flat for at least one year to exchange his flat with another HDB lessee. Nevertheless, the primary purpose is to enable parents and married children to exchange their existing flats with others so that they can live closer to one another. According to data provided by the Housing Development Board, between the years 1981-85, there were only 290 cases. There are two main reasons for this. Firstly, it is not easy to find a desirable flat which is at the same time near the unit occupied by one's family member. Secondly, the owner of a new flat is usually reluctant to exchange for an older unit even though the location is right.

The Reside Near Parents Married Children Scheme is another attempt to enable parents and married children to live in the same block of flats or within the same housing estate, particularly for those who are applicants or tenants of rental flats. As indicated by senior officials in the Housing Development Board, this scheme also permits parents, who may be unable to purchase new or larger flats in a new town, to reside in rental flats within the same housing estates as their married children who have purchased home ownership flats in the same vicinity. Nevertheless, this scheme, though useful in bringing parents and married children close together, has had limited success, primarily because the waiting list for rental flats is relatively short. Nevertheless, during the years 1979-1985, 2,030 cases benefited from this scheme.

Lastly, the Multi-Tier Family Housing Scheme, introduced in May 1982, actively encourages parents and married children to live within the same dwelling unit. A multi-tier family is defined as one where parents and one or more married children's families are listed in the same application for one unit of flat either for rental or purchase. The most welcomed feature is that allocation of flats to eligible multi-tier families is accorded a three-year headstart. They can get their flats three years earlier than other applicants. Furthermore, existing applicants of a three-room flat on the waiting list are allowed to change to either a four-room or a five-room unit under this scheme without any loss in priority; in addition, the three-year headstart is also given. Response from the public has been fairly good. During the years 1982-85, 11,000 eligible applications were received.

In Hong Kong, we do have the "Elderly Housing Priority Scheme" wherein those families who have aged parents at the age of 60 and above can have a one year jump in the queue when they apply for a flat in public housing estates. However, when the reality is that the normal waiting period is at least seven to eight years for such a flat, a year's jump is of little attraction.

Generally speaking, among the different housing schemes to support family care of the elderly, the Joint Balloting Scheme in Singapore appears to have enjoyed the most success. Compared to the Multi-Tier Family Housing Scheme, the Joint Balloting Scheme provides for the advantages of extended family living while safeguarding the independence and privacy of each family unit, or, to use Eugene Litwak's term, the modified extended family is being encouraged to promote family care of the elderly in the community (Litwak, 1986).

Conclusions

As a social group, the elderly are diverse in their housing needs and preferences. Some may prefer to continue to live in retirement communities or sheltered housing segregated from the rest of the age groups. To conclude, I tend to agree with Alan Butler and Anthea Tinker (1982) that what some older people appear to require is housing which to some extent insulates, not isolates; i.e., insulates them against ego-despair as described by Erikson (1971). I do believe that elderly people should be given the opportunity to choose the type of housing they prefer.

Despite the trend towards community care, a dual approach walking on two legs is hereby advocated. The front leg walks on the guiding principle that more active housing policies to support the family institution to care for the elderly, like those adopted by Singapore, should be devised with the aim of enabling old people to stay longer in their existing homes, should that be their wish. The rear leg functions on the policy that sheltered and segregated housing should also be formulated as a viable housing option for those old people who prefer this type of life style.

It appears to me that what the elderly people really need is a house which they can accept as home, and not just simple shelter.

References

Bayley, M. (1973). *Mental handicap and community care.* London: Routledge and Kegan Paul.

Bayley, M. et al. (1981). *Origins, strategy and proposed evaluation, neighbourhood services project - Dinnington.* Paper No. 1, University of Sheffield, Department of Sociological Studies.

Bromley, D.B., (1984). *Gerontology: social and behavioural perspectives.* Croom Helm: London.

Butler, A., Oldman, C., & Greve, J. (1983). *Sheltered housing for the elderly.* London: George Allen & Unwin.

Butler, R., (1978-79). Public interest report no. 26: Compassion and relief from pain, *International Journal of Aging and Human Development, 9,* 193 -195.

Chow, E., (1983). An evaluation of the "Special Quota Grant", An Alternative to hostel care for the aged in Hong Kong. Department of Social Work, University of Hong Kong.

Department of the Environment. (1980). *Housing the elderly near relatives: moving and other options,* London: H.M.S.O.

Department of Health & Social Security. (1983). *Elderly people in the community: their service needs: research contributions to the development of policy and practice,* London: H.M.S.O.

Department of Social Work. (1982). *A study of the welfare needs of the elderly in Hong Kong.* University of Hong Kong.

Downs, R.M. & Stea, D. (eds.). (1973). *Image and environment: cognitive mapping and spatial behaviour*. London: Edward Arnold.

Golant, S.M., (1985). In defense of age-segregated housing, *Aging Magazine*, No. 348, 22-26, Administration on Aging, U.S. Department of Health and Human Services.

Golant, S. (1976). Intraurban transportation needs and problems of the elderly. In M.P. Lawton et al. (Eds), *Community planning for an aging society*. pp. 282-308. Stroudsburg, Pa.: Dowden, Hutchinson and Ross.

Government Secretariat. (1982). *Programme plan for the elderly: A review*. Hong Kong.

Hancock, J.A. (1987). *Housing the elderly*. Centre for Urban Policy Research, N.J.

Heumann, L. and Boldy, D. (1982). *Housing for the elderly*. Kent: Croom Helm.

Hobman, D. (1981). *The impact of aging*. Kent: Croom Helm Ltd.

Hochschild, A.R. (1973). *The unexpected community,*. Englewood Cliffs, N.J.:Prentice-Hall.

Housing Development Board. Annual Report 1986-87. Republic of Singapore.

Housing Department. (1986). *Survey on the housing conditions of tenants in "Special Quota Housing Scheme for the Elderly"*. Hong Kong.

Huttman, E., *(1985). Social services for the elderly*. New York: The Free Press.

Kwan, A., (1986). *A survey on the "Special Quota Housing Scheme" for the elderly in Shun Lee Estate*.. Hong Kong.

Lawton, M.P., (1970). Institutions for the aged: Theory, content and methods for research. *The Gerontologist. 10* 305-312.

Lawton, M.P., (1975). *Planning and managing housing for the elderly.* New York: John Wiley & Sons Inc.

Lawton, M.P., (1980). *Environment and aging.* Brooks/Cole Publishing Co.

Li Y. & Yang K.. *Symposium on the character of the Chinese*. Institute of Ethnology Academic Sinica Monograph Seriers B, No. 1, Taipei.

Lipman, A. & Slater, R., (1977). Homes for old people: towards a positive environment. *The Gerontologist, 17* 146-156.

Litwak, E., (1965). Extended kin relationships in an industrial democratic society. In Shanas, E. and Streib, G. (Eds), *Social structure and the family: Generational relation*, New Jersey: Prentice Hall.

Ministry of Health, (1984). *Report of the committee on problems of the aged,*. Singapore.

Ministry of Social Affairs, (1984). *Report on the national survey of senior citizens.* Singapore.

Monk, A., (1985). *Handbook of gerontological services. New York:* Van Nostrand Reinhold Co.

Montgomery, J.E., (1972). The housing patterns of older families. *The Family Coordinator.* 37-45.

Mumford, L., (1956). For older people - not segregation but integration. *Architectural Record.*

Pastalan, L. (Ed.), (1983). *Retirement communities: An American original.* New York: Hawthorn Books.

Phillipson, C. & Walker, A., (1986). *Ageing and Social Policy: A critical assessment.* Hants, England: Gower Publishing Co. Ltd.

Race, D., (1982). *Residential and Institutional Services for the Elderly.* Department of Social Work, University of Hong Kong.

Rosow, I., (1967). *Social integration of the aged.* New York: Free Press.

Shanas, E., et. al., (1968). *Old people in three industrial societies.* London: Routledge & Kegan Paul.

Shanas, E., The family as a social support system in old age, *The Gerontologist. 19,* 169-174.

Wilcocks, D., Peace, S., & Kellaher, L., (1987). *Private lives in public places: A research-based critique of residential life in local authority old people's homes.* London: Tavistock Publications.

Yelaja, S.A., (1978). Subsidized housing for the elderly: Importance of choice. Paper presented at the International Conference of Gerontlogy in Tokyo.

CHAPTER 15

SOCIAL SUPPORT NETWORKS FOR THE ELDERLY IN A HIGH-RISE PUBLIC HOUSING ESTATE IN SINGAPORE

Paul P.L. Cheung

Introduction

In the past fifteen years, caring for the aged has been a major social welfare concern for the Singapore government. The plight of the destitute immigrant aged, of Indian or Chinese origin, aroused much public sympathy. The breakdown of the informal support systems for this group was obvious, and immediate remedial actions were taken by the government and voluntary organizations to provide a reasonable level of care for their daily living. It is, however, a general belief that the problem of coping with the destitute immigrant aged is time-bound; with the passage of these cohorts, the seriousness of the problem is likely to be reduced.

Although the burden of caring for the destitute aged could be diminished over time, the extraordinary success of Singapore in socioeconomic development and in family planning brings forth new concerns. In 1986, Singapore's fertility rates were among the lowest in the world, and it is probably the first developing country to have a sustained and prolonged below-replacement fertility. Population projections show that the proportion aged 60 years and above is likely to increase from 8% in 1987 to 26% in 2030. The National population figure in 1987 was 2,590,000 and is estimated to be 3,214,000 in 2030.

The rapid increase in the absolute size as well as in the percentage share of the aged injects a new sense of urgency in dealing with the growing welfare burden of the aged, along with the realization that population ageing has wide-ranging socio-economic implications. With the rapid socio-economic changes and growing Western influence on the Singapore way of life, there is a growing concern of whether the traditional support systems for the aged will continue to function effectively.

Although the government has taken an increasingly active role in the provision of care to the aged, it still expects the traditional support systems to bear the major burden. This is a matter of official policy. The government would provide care only as a last resort, and would allocate financial resources only if absolutely necessary.

To ensure that an adequate safety-net has been put into place, it is therefore necessary to assess the current balance of formal and informal support systems provided to the aged. No systematic research has been carried out thus far to assess the informal support systems of the aged, their levels of utilization, and their access patterns. In a multi-racial society like Singapore's, the complementarity and reciprocity of the formal and informal support systems are complex issues that need to be carefully delineated within, and across, racial and other social boundaries.

To this end, a research project is currently underway to study the matter. Sponsored by the United Nations University in Japan, the objectives of the project are to examine the current support systems for the aged in the socio-historical context of society, to scrutinize their adequacy, and to explore policy implications. This paper draws on the preliminary findings of the project.

Types of Social Support Systems

Traditional Support Systems

Singapore, a city-state of 2,590,000 people, is essentially a country of elderly immigrants. In 1921, only 29.1% of the population were local-born. At that time, the bachelor immigrant dormitories constituted an important social group and met many of the needs of the immigrants. Since then, the proportion of local-born persons has increased steadily, reaching over 80% in 1980. Associated with this social transformation is the gradual increase in the generational depth and complexity of the family institution, and the passing of the single immigrant aged.

The immigrant population comprises two groups: the Indians and the Chinese. The Malay elderly are mostly local-born and their community is traditionally very strong in its social support to those in need. The Chinese immigrants have placed a greater reliance on the formal associations, such as the 'kongsis' and the clan association, as a source of social and economic support. Basically, the Chinese society in the early days was a commercial society divided along the lines of 'bang,' which means a grouping. It represents a Chinese politico-socio-economic grouping based principally on dialect similarity.

The proliferation of various forms of Chinese associations was initially induced by the need to provide shelter, food, clothing and jobs for new migrants. Subsequently, these associations also met other needs, such as places for religious and ancestor worship, cemeteries, social gatherings, and even law and order. The importance of these formal associations cannot be over-emphasized, as their activities touched every aspect of an immigrant's daily life. Indeed, the associations were the center of social life for these cultural enclaves.

The Chinese associations had great impact on the social provisions during the colonial era under the British. Each major association had its own building, school, hospital, cemetery, specific occupation and spatial concentration. Many of the original functions performed by these associations were curtailed when the flow of Chinese immigrants to Singapore ebbed and finally ceased. Reliance on these formal support systems was reduced when an immigrant started a family. However, among the single immigrants, the reliance and ties with these clans continued into their old age, and would include such matters as funeral arrangements.

The reliance of the Indians on the formal associations is less clear. For the early Indian immigrants, the living arrangements and social support networks emerged along the lines of the typical Indian culture in India. Much of their cultural system and mutual help system were preserved intact when they came to Singapore.

Group dwellings or tenements were the main mode of accommodation for these Indian migrants. Each of these group tenements were divided along the lines of caste and districts where the migrants came from. There were also caste group associations based on various districts in South India and communal group associations. Such associations operated very much like the Chinese 'kongsis' or clan associations. Accommodations were provided and employment secured on behalf of the migrants. With the passage of time, settling disputes and providing financial aid in times of sickness or unemployment were also part of the associations' functions.

The associations and clans of each immigrant ethnic group became important sources of help and support for the migrants who remained single. These organizations did not start out as social support systems for the elderly per se. Their functions were reflective of the needs, and socio-economic and political situations at that time. Singapore's governmental infrastructure was rudimentary and welfare was very much a community affair. The British adopted a 'laissez-faire' approach and pretty much left the various ethnic groups to administer their own brand of social services.

Changes to Traditional Support Systems

However, in recent years, these traditional support systems have been on the decline and pleadings for their revival are often heard in the public media. In the meantime, the government is somewhat forced by circumstances to make provisions for care of the immigrant aged who have no other means of support. Such governmental action is to be regarded at the present moment as an interim measure. As the marital composition of the aged changes over time, there is also a corresponding change in the relative significance of the familial and non-familial support systems.

Other developmental changes in Singapore have an equally important impact on the care of the aged. The resettlement into public housing estates, which now house some 85% of Singapore's population, has contributed to the breaking up of the village community.

Research has shown that neighbors continue to play a role, but the level as well as the kind of support expected has changed. Mere cordiality and superficiality appear to be the norm.

Current Formal Support Systems

Unlike some Western countries, there is no universal welfare scheme for the elderly in Singapore. The basic philosophy is that the existing system of family care and concern must be maintained, and the family must ultimately be responsible for its elderly dependents. Institutionalization should be used only as a last resort. The aim is also to obtain as much community participation as possible.

The government has been sufficiently alarmed by the adverse implications of population ageing. A public committee chaired by the then Minister for Health was formed and, subsequently, a report was released in 1984 (Ministry of Health, 1984). Two features characterize the government's approach to dealing with the problem. First, the government, as a matter of policy, is reluctant to allocate additional financial resources to welfare services for the aged. This reflects a long-standing fear that the government has of falling into the pitfalls of a welfare state. The thrust of the policy, then, is to let the informal support systems take over as much responsibility as possible. Thus, admission to government homes is restricted only to the destitute aged and the public assistance scheme imposes a strict means test. The welfare burden of the aged will be increasingly shouldered by voluntary groups and the family, and additional efforts will be taken by the government to encourage the growth of an elaborate community-based care system.

Second, the government hopes to reduce the welfare burden of a large aged population through preventive social legislation. The compulsory Central Provident Fund (CPF) scheme requires a person to save a significant portion of his monthly income as a source of financial security after retirement. Until very recently, employers were required to contribute an equal amount. In 1988, the employees contribute 24%, while the employer's contribution has been fixed at

12% of the employee's monthly income. Part of the CPF fund is channelled into the Medisave account to pay for medical care. Other legislation concerns the employment of older workers, housing privileges, and familial responsibility. The emphasis on the primacy of the informal support systems by the government is interesting, but it remains to be seen whether a sufficient safety-net for the aged has been put into place.

There are a number of welfare services available for the elderly, provided jointly by the Ministry of Community Development and by voluntary, community and religious groups. These services include:

Financial Support Services

A total of 26 voluntary and religious organizations affiliated with the Singapore Council of Social Service render assistance in cash and kind to the financially distressed, including the elderly. These organizations supplement the government's Public Assistance Scheme and related charitable funds managed by the Ministry of Community Development.

The Public Assistance Scheme provides monthly allowances ranging from $120 for single-person households to $295 for 4-person households. Recipients must be Singapore citizens. In 1983, direct financial assistance was given to 2,850 persons aged 60 and older, or 1.5% of the elderly population.

The government also provides subsidies or indirect financial assistance to voluntary welfare organizations operating homes of the elderly. This takes the form of a nominal Temporary Occupation License (TOL) fee of $12 per year for premises and land used for the operation of these homes. Other forms of government subsidies include free outpatient care and hospitalization for the needy, and provision of staff and training programs.

Health and Recreational Support Services

Health and recreational support services for the elderly were only introduced in the early 1980s. These services, provided mainly by civic or voluntary organizations, are concentrated in senior citizens' clubs. Managed mainly by volunteers, the senior citizens' clubs provide recreational programs, health screening, keep fit programs and opportunities for community service. Membership in these clubs is open to all ambulant elderly aged 55 and older, and is either free or subject to a nominal fee (ranging from $1 per year for ordinary membership to $5 per year for life membership). In October 1987, there were 152 senior citizens' clubs. Among them, 66 were organized by the People's Association, 66 by Residents' Committees, 14 by Citizens' Consultative Committees, and 6 by voluntary organizations. The estimated membership in these clubs in 1987 was 38,000 or 18% of the elderly population.

Retirees are also able to join the Retirees' Club run by the People's Association. The aim of the Club is to help members prepare for and deal with retirement and to provide information on employment and community work for retirees.

As of the third quarter of 1987, 26 grass root groups had held health fairs and free health screenings for the elderly. These activities are organized in conjunction with the Ministries of Health and Community Development.

Community Support Services

Run largely by voluntary organizations and individual volunteers, these include:

(a) Befriender Service;
(b) Home Help Service;
(c) Meal Services;
(d) Home Nursing Service;
(e) Day Care Centers; and
(f) Respite Care Service.

(a) Befriender Service

This is essentially a "good neighbor" program comprising concerned citizens who befriend, advise and assist lonely senior citizens in coping with the demands of daily living. They also act as points of contact in times of need or crisis. The Befriender Service caters to senior citizens who live alone or with an elderly spouse or flatmate. Elderly couples with children can also apply if their children are unable to look after them. The volunteers make home visits on a regular or ad hoc basis. Besides providing companionship and outings, the volunteers also offer services such as housekeeping and run errands on behalf of the elderly. The majority of these volunteers are housewives. Many of the activities organized by this service are supported through contributions from the community. As of March 1987, 16% of the users of this service were living alone, 16% with a spouse, 40% with an elderly room-mate, and 11% with children.

(b) Home Help Service

The Home Help Service, introduced in January 1986, enables an elderly person to stay comfortably in his own home with the assistance of a home helper. The objective of this service is to offer individuals and families, at a fee, domestic assistance and help for the elderly. This is to relieve the family of the strain of providing continuous care to the elderly, to enable family members to continue working, and to enable the elderly to continue living in their own homes.

There were 53 home helpers and 61 home helper users as of March 1987. The helpers are mainly housewives aged 30-50 years who wanted to do some work during their spare time. The helper specifies the number of hours per day or per week that she is prepared to work and fees, normally between $2.50 and $3.50 per hour, are negotiated between helper and user. Those unable to pay are referred to civic groups for financial assistance.

(c) Meal Services

Started in 1976 by the Salvation Army Central Corps, the meal service program provides meals to those elderly who have little means of supporting themselves. Two types of services are available: luncheon clubs and meal delivery service. Luncheon clubs are run by senior citizens' clubs, voluntary organizations, and religious groups in central locations and are popular with ambulant elderly. The meals are either provided free or at a nominal charge of 50 cents per person. The meal delivery service is part of the services provided to homebound elderly by the Befriender Service.

(d) Home Nursing

The Home Nursing Foundation is a voluntary organization providing nursing care to the non-ambulant, aged, sick, and disabled in their own homes. It also trains family members to care for their elderly sick. The foundation also operates senior citizens' health care centers in public housing estates, providing day care, rehabilitation, health education, health screening, and counselling.

(e) Day Care Centers

Day care services provide domiciliary services to frail elderly at central locations. Senior citizens aged 55 and above who are ambulant or semi-ambulant are accepted. Bedridden elderly, however, are not accepted. The centers provide basic nursing care and simple physiotherapy for those elderly who require rehabilitative care following discharge from hospitals. They also provide a place where the elderly can spend the day while family members are at work. Currently, there are five day care centers which provide rehabilitation programs and three which provide only social activities.

(f) Respite Care Services

Respite care service is an alternative care arrangement that provides nursing and personal care to the elderly who is convalescing or temporarily unable to maintain themselves in their own homes.

This is only a short term arrangement which allows family care givers a short break to recuperate from the continual care of the dependent elderly. Currently, there are nine voluntary respite care centers. Fees are determined by user and provider.

(g) Counselling Service

Counselling services are provided by the government and three voluntary welfare organizations. These services provide an avenue whereby the elderly can settle their financial problems and family disputes.

Institutional Care Services

Admission into a home for the aged is viewed as an extreme measure. While such homes cannot be dispensed with altogether, great care is taken to ensure that they are confined to those who, for reasons of physical or mental infirmity, cannot be cared for in their own homes.

Institutional care for the elderly is provided by the government and by voluntary and commercial organizations. As of October 1987, there were 68 such institutions providing a total of 4,948 beds. These institutions cater to elderly who are destitute, incapable of self care, or whose family members are unable to care for them. Nursing care is also given to the sick, semi- and non-ambulant.

The three government homes (Woody Lodge, Pelangi Home, and Woodlands Home for the Aged) cater to the elderly and destitute. These homes together provide a total of 1,525 beds. Residents are provided with a number of facilities and activities, ranging from work placement to leisure activities. At the Woodlands Home, for example, all able-bodied residents are encouraged to participate in a home employment program. As of December 1987, 147 residents have been placed under the scheme, doing light household chores.

Voluntary welfare homes receive support from the Community Chest of Singapore and from religious and social organizations. The Ministry of Community Development supplements this by giving eligible residents free medical benefits and a monthly public assistance allowance, from which they are expected to contribute a certain proportion for their own upkeep. There is also a one-time payment which ranges from $1,000 to $3,000. Fees charged by commercial homes range from $200 to $800 per month.

Informal Support Systems: The Family

In Singapore, the care of the elderly falls primarily on the family. As generally observed, the family is functionally more suited to perform the caring role than other forms of organization. The question is whether the capability of the family system can be maintained.

Living Arrangements

A survey conducted in 1983 showed that about 87% of the elderly lived with their immediate family. Another 8% were living with relatives or friends, and only 5% were living alone. The majority of those living alone were unmarried immigrant workers who had no family links. Survey findings indicated that there was a strong preference among the elderly to live with their married children. Cultural factors, however, do influence the choice of co-residence: the Chinese preferred to live with their married sons while the Malays their married daughters. The prevalence of the elderly living alone may increase in the future as they become more independent financially and socially. Such living arrangements would more likely be a function of choice, rather than a result of personal circumstances. The cultural ethos of intergenerational co-residence, however, is unlikely to change drastically.

Home ownership is fairly common among the elderly in Singapore. In 1986, about 40% of them owned the properties they were living in. Another 40% lived in properties owned by other family members. The proportion of home owners is expected to rise in future years with the government's push for 100% home ownership.

Surveys have consistently shown that there is an overwhelming reluctance among the elderly to stay in old folks' homes. Surveys of younger respondents also showed that they would not consent to have their parents live in an institution. At present, the institutionalized aged constitute only 2% of the total population. The majority of the inmates are immigrant aged with no family ties in Singapore.

Family Support

A 1986 national survey of the aged living in the community reaffirmed the belief that the family constitutes the main source of assistance and support for the aged. It showed that the primary source of financial support for the elderly came from children and grandchildren, and 86% of the sample were receiving financial contributions from their family. Family members also helped when the elderly fell ill. The most commonly mentioned caregivers during illness were spouses, followed by daughters and daughters-in-law. Family members also helped with personal problems.

The pattern just described should not come as a surprise as the family has always been the primary caregiver for its aged members. The pertinent issue here is perhaps the degree to which family supports have been found wanting among the elderly. Is it possible that, in the future, the family will be less willing to shoulder such responsibilities? In Singapore, evidence has not emerged to suggest that the family is shirking its responsibilities to the elderly.

The increase in the generational depth and complexity of the family has enhanced the capacity of the family to care for the aged, in spite of the fact that the nuclear family remains the predominant structural form in Singapore. The close geographical proximity, the pooling of economic and manpower resources, and the continuing tradition of honoring the elderly enable the children, though living separately, to meet their filial obligations. There are, however, signs of stress in this support system. The economic prosperity of Singapore has created many employment opportunities for the married woman. The choice of external employment has thus reduced their availability as caregivers. Concerns have also been raised about the negative influence of Western values and the possible decline of filial piety. As a counter-measure, the government has introduced a curriculum of moral education and a wider variety of religious subjects including Confucianism among the schools. There have also been hints of possible legislation on obligatory family support for the aged. Finally, the rapid decline in family size may threaten the viability of the family as a caregiving institution. It is indeed quite difficult for a singleton, or even a sub-set of two, to care for a bedridden parent on a long-term basis. The luxury of having a large number of siblings to help out has simply become a thing of the past. However, the effects of these factors have not been empirically assessed.

The fact that the family is the primary support source poses the question of whether the elderly should be expected to rely solely on this source. Variations in the quality of family support do exist, and they must not be assumed to be of consistently high quality. The tyranny of the family, no matter how well intended, could well be intolerable to an elderly person, dependent as he may be. The availability of choices with respect to the sources of support is an important, but often ignored, consideration.

State and Family

As the Singapore government holds the view that the family should be encouraged to care for its elderly members to the fullest extent possible, specific policies have been enacted to achieve this objective. The interaction between the state and the family is interesting and it shows vividly how family life could become a target for policy intervention. These policies are:

1. **Multi-tier Family Housing Scheme**. Implemented in 1982, this scheme encourages multigeneration families to remain intact in spite of reallocation or urban renewal. Applications for public housing apartments under this scheme are given priority in allocation.

2. Joint Application Scheme. Implemented in 1976, this scheme allows married children and their parents to be allocated adjoining apartments in their applications for public housing.

3. Income Tax Reliefs. A $1,000 income tax relief is allowed to a person who is caring for an aged dependent, on the condition that the aged family member is not earning more than $1,500 a year. Moreover, children can claim tax relief up to $6,000 per year for the equivalent sum of money they have contributed to their parents' Central Provident Fund account. This is to encourage the children to save for their parents' financial security and protection.

4. Moral Education Program. The government has initiated changes and additions in the schools' curricula to strengthen the traditional familial values and the inculcation of filial piety and respect for the elderly. An annual senior-citizens' week is being organized to promote the contributions and the status of the elderly. A family life education program has also been implemented to promote harmonious family living.

5. Community-based Services. To help reduce the burden of care on the family, a conscious effort of promoting community-based services is made. Services such as home nursing, home visiting, day care, and respite care have been offered.

6. Legislative Initiatives. The 1984 Committee has recommended that laws be passed to impose an obligation on children to provide for the financial security of their parents. Such legislation would serve as a deterrent to unfilial children who would otherwise evade their responsibilities and to codify an obligation that the society endorses. However, no legislation has thus far been introduced.

Is this approach likely to be effective? This policy reflects to a large extent the cultural emphasis of the centrality of the family and is therefore not at odds with the general sentiment. The policy measures such as housing allocation privileges facilitate and reinforce, where possible, the intergenerational linkages. Family support is made possible through the proximity of residence. Furthermore, the home ownership scheme provides the future cohorts of the elderly a meaningful level of status and protection in the family.

These, however, are passive measures, allowing existing relations to be maintained rather than fostering closer ties. In this regard, the moral education and the family life education programs represent the active steps in trying to inculcate specific attitudes. Westernization has been rapid in Singapore and there is a fear that the traditional mores and familial values will be replaced by Western individualism. Critics have argued that this fear is largely unfounded, and the government's programs help only to reinforce what is already there. Whether the intervention by the government could help to prevent this possible surge of individuals remains to be seen. But the government is prepared, if necessary, to legislate familial obligations should the family be seen to have shirked its responsibilities.

Informal Support Systems: Neighbors

From an urbanization and physical development perspective, neighboring practices in high-rise and high-density public housing estates in Singapore have a direct bearing on the social support systems of their residents. Logically, the physical setting of the HDB (Housing and Development Board) new towns should allow ample opportunities for families and individuals living close to each other to develop neighborly ties over time which, in turn, should foster a sense of mutual social support in times of need.

However, the logic is not so simple and straightforward. Given Singapore's multi-ethnic, multi-religious, multi-language and multi-cultural nature, certain caveats apply. Differences within a heterogeneous population affect the degree and extent of neighborliness and hence social support between neighbors. The situation is also compounded by the phenomenon of urban industrialism to some extent, notably the "Gesellschaft" effect. It must be remembered that Singapore is largely an urban country and one of the NICs (newly-industrialized countries). At the same time, despite the heterogeneity of its people, their common Asian cultural backgrounds can help mitigate the forces which hinder social interaction. There are also the efforts by the government and community organizations to actively promote neighborliness among residents. On their part, urban and physical planners also try to counteract the negative aspects of urban life by designing and building certain environmental and building features and facilities which help to enhance cooperative and cohesive living among residents. As such, neighboring practices in Singapore are tempered by the societal context in which they occur. What then, is the practice of neighboring among flat dwellers, particularly as it relates to the development and maintenance of informal social support systems of the elderly and other age groups? A number of studies have examined various aspects of neighboring practices among public housing residents in Singapore. We will review the major findings in this section.

Neighboring can take various forms. For our purpose, we shall focus on neighboring as forms of social interaction among neighbors, some of which manifest themselves as instances of social support. Examples of neighboring are greetings between residents when they happen to meet at the void decks, exchanging food and gifts whether during special occasions or as routine, dropping in to the neighbor's flat for a chat, helping to tend to one's neighbor when he or she is ill or incapacitated, and confiding in the neighbor with one's problems.

A national study of public housing estates by Yeung and Yeh (1975) on the extent of neighborliness, as indicated by the frequency of social visits of at least once a week between neighbors, found that on the average, at most only one third of them did so. What are the factors which promote such visits? The study found that one of the biggest reasons is the presence of children living on the same floor playing together (38%). Next comes the proximity of living next-door to each other, followed by living on the same floor (23%). The proportion drops to 11% for those living on other floors in the same block and 9% for those residing in other blocks in the same locality. For those who do have social visits, 62% do so with 1 to 6 households living on the same floor, compared to 26% with households located on other floors in the same block, and 34% with residents staying in the other blocks in the estate (p. 274). By contrast, 33% of households do not make social visits to any of their neighbors living on the same floor, 72% with neighbors living on the other floors and 59% with residents staying in the other blocks in the same estate.

In an update of the national study mentioned earlier, a similar survey carried out in 1981 found the following:

> The most common form of neighboring identified by the survey is the exchange of casual conversation which more than 90 percent of households engage in with at least one or two neighbors and the majority (61 percent) with at least five neighbors. The survey also reveals that as neighboring "intensifies" beyond the level of casual conversation to activities such as paying social visits, exchanging food on festive occasions, holding joint activities, helping in personal or financial problems and in childcare, involvement is progressively with fewer neighbors (Wong, Ooi, & Ponniah, 1985, p. 470).

The 1981 survey also found that certain physical features of the blocks and their environs contribute to the neighborliness of the residents:

> The regular use of facilities brings the residents into frequent contact with each other as their daily paths cross. Such encounters enable residents to recognize each other and exchange greetings, from which some develop more intense levels of neighboring. In the case of the use of facilities, the form and the extent of neighboring vary, with housewives, pri-

> mary school children and elderly people being more likely to go beyond the casual level of neighboring, and working adults and working youths being the least likely (Wong, Ooi, & Ponniah, 1985, p. 490).

For the elderly, going beyond the casual level of neighboring is related to the fact that they tend to be more estate-bound, due to a combination of economic, health and other factors. The 1981 study explains:

> One-half of the elderly interviewed seldom venture beyond their own and neighboring blocks, either because of poor health or difficulty with remembering places. More than half of them spend some time daily in the void decks, either with their grandchildren or with neighbors. Half of the elderly men frequent the local coffee shops. Among those who live near the town center, nearly all take strolls in the shopping area because it is usually more lively there. Hence the daily movements and leisure activities of the elderly occur almost entirely within the estate (Wong, Ooi, & Ponniah, 1985, p. 490).

Clementi New Town: A Case Study

Background -- Public Housing and New Towns in Singapore

Eighty-five percent of Singapore's population of 2.59 million people are staying in public housing (Ministry of Communications and Information, 1987). There are at least half a million public housing flats in Singapore (Chong et al., 1985). They are managed by the nations's sole public housing authority, the Housing and Development Board (HDB). Together with the flats, the HDB is also providing some 33,000 commercial premises (shops, hawker stalls/pitches and offices), 8,500 industrial premises (like workshops and factories), and about 250,000 other facilities and amenities, e.g., child care centers, education centers, community homes for the elderly, bus bays and parking lots (Chong et al., 1985).

The HDB is a quasi-government organization created in 1960 to build and manage affordable and decent housing for the majority of the people in a livable environment which fosters "a viable and cohesive urban community" (Lim et al., 1985). To date, it has planned, constructed and developed 16 high-rise and high-density new towns for Singapore (Tan et al., 1985, p. 375).

A public housing new town is planned to be a geographically distinct and self-sufficient satellite town with its own town center and a number of neighborhood centers supporting a large population of between 13,000 to 66,000 households (Tan et al., 1985, p.375). It has a range of "basic services and facilities like markets, shops, schools, public transport, medical services and cultural and recreational" amenities (Wong, Ooi, & Ponniah, 1985 p. 458). Often, it will have an industrial estate adjoining it offering employment to a large proportion of its residents.

Clementi New Town

Clementi New Town follows the urban planning concepts and philosophy outlined earlier. Situated in the southwestern part of the country, it is 11 to 13 kilometers from the central business district. It occupies 433 hectares, with 146 hectares allocated as residential areas (Housing and development Board Annual Report, 1966).

Its population was estimated to be 103,400 people in 1987 (Housing and Development Board Annual Report, 1986). Residents started staying in the estate around 1977. A good mix of Chinese, Indians, Malays, and other ethnic residents with lower to middle-lower socioeconomic characteristics can be found in it.

Typical of the new towns built in the mid-1970s onwards (Tan et al., 1985), Clementi's town center has a wide range of shops, supermarkets, restaurants (including fast food chains like McDonalds and Kentucky Fried Chicken), a large hawker center, a wet market, banks, a post office, a government polyclinic, a number of private medical clinics, a music school, two cinemas, a bus interchange, a HDB Area Office and a Community Hall, among other amenities. Located in various parts of the estate are a number of primary and secondary schools, playgrounds, public parks, and various grassroots and social service organizations, such as Residents' Committees, Community Centers, child care centers, educational centers, Boys' Clubs, a school social work agency, a residential home for the elderly, and senior citizens' clubs. There are also sports and swimming complexes.

Clementi New Town contains the following number of flat types and flats (Housing and Development Board Annual Report, 1986).

Flat Type	No. of Flats
1-room	484
2-room	656
3-room	13,289
4-room	7,000
5-room	2,108
Executive	513
Total	24,050

The flats are constructed in blocks of buildings which range from 2-story shophouses to 25-story point blocks, with the majority in blocks that are 12-stories high. Floor area ranges from 33 sq. meters for a 1-room flat to 145 sq. meters for an Executive apartment.

Prices in 1987 under the home ownership scheme for new town flats ranged from $22,700 for a 3-room improved flat to $103,700 for an Executive flat (a 6-room apartment) (Housing and Development Board Annual Report, 1986). For flats available under the rental scheme, monthly rates are $40 for a 1-room flat to $100 for the 3-room type.

As mentioned earlier, HDB new towns are planned on the principle of self-sufficiency. Thus, Clementi has its own range of services and amenities. There is, in fact, a hierarchy of services. The higher value services are available in the town center while the lower value services are found in the neighborhood centers (Wong, Ooi, & Ponniah, 1985). So only certain services and facilities can be found in the town center, while others are distributed at both the town and neighborhood centers. This is because, for many residents, the town center is not within walking distance. Hence, going to the center becomes an occasional outing.

To make it easier for residents to do their shopping/marketing, neighborhood centers have been developed. The centers are planned to be, in principle, within five minutes walk from any point in the neighborhood. They consist of a wet market, usually a small one.

Because of the preference for fresh food, daily shopping is necessary. It is not surprising to find homemakers, elderly men and women gathered around the market and food center. Therefore, the center becomes a locus of interaction for all who gather there. Although the services available in HDB estates are for all residents, the extent to which the individual uses the services depends on the life stage of the individual. For example, we found that the homemakers and the elderly tend to make use of market facilities more often than working adults. The latter prefer shopping in supermarkets near their places of work or conveniently located along their transport routes.

The flats in each zone are clustered together with a focal point to encourage interaction and territorialism as well. This is, in effect, the Precinct concept. A precinct consists of a cluster of blocks arranged around a central open space with associated facilities. "It is intended to demarcate a territory for residents to identify with, as well as be a setting which, through use of common facilities, will catalyse social interaction and community spirit" (Tan et al., 1985, p.90). Examples of focal points in different localities in the estate are the playgrounds and void decks. In one neighborhood, there is a "neighborhood circle," a landscaped open ground for residents. Every morning and evening the elderly gather at the circle and chat. The place is centrally located such that people walking to and from the flats to the grocery shops have to pass the circle. Many of them stop to chat with friends and neighbors on their way home. Sometimes the circle is used as a meeting point for friends. In other neighborhoods, the market square is the main point for interaction.

The estate is planned such that there is in each neighborhood zone an education center which serves as a kindergarten in the morning and as adult education centers in the evenings. Apart from this, there are three major community or "grassroots" organizations.

The first is the Community Center, which is managed by a Management Committee (CCMC). As its name indicates, the CCMC runs the Clementi County Center and two sub-centers at two other places in the estate. The Community Center holds activities for residents in the whole of Clementi estate. Among their many clubs is the Senior Citizens' Club which has a membership of more than 700 elderly persons. All Community Centers in Singapore are built with funds jointly raised by the CCMSs and grants from the government. The day-to-day running of the Centers come under the jurisdiction of the CCMCs, while policy matters are the purview of the People's Association, a quasi-government organization responsible for the existence of the Community Centers.

The Residents' Committees (RCs) are "grassroots" organizations comprising local residents appointed by the Prime Minister's Office and supported administratively by the staff of the RC Secretariats. They each look after a few blocks in the estate. They deal mainly with security matters, against crime for example, as well as organize community activities, including those for senior citizens. The aims of the RCs are the promotion of neighborliness, the development of a sense of belonging and identity among the residents, and the encouragement of mass participation in community activities. Each of the neighborhoods has a RC. One of the Chairmen of a RC, himself an elderly person, explained that the main purpose of having a club for senior residents is to integrate the elderly into the community by organizing activities for them.

The Citizens Consultative Committee (CCC) is yet another community organization. It coordinates the efforts of the CCMC, the Residents' Committees, and other local organizations and plays a leading role in promoting national campaigns or constituency projects, like Senior Citizens' Week. It also makes recommendations to the government regarding matters affecting the whole constituency, for example, the provision of better bus services or other facilities to meet the needs of residents. Its members consist of prominent local community and business leaders appointed by the Prime Minister's Office with the advice of the local Member of Parliament.

Clementi also has the St. Andrew's Cathedral Home for the Aged, which is a home for ambulant elderly women. It is a voluntary welfare organization set up by the Anglican church and relies on public donations for its upkeep. Clementi residents as well as those from other places in Singapore are eligible to stay in the Home if they qualify for admission. To qualify, they must be dependent and without children to support them.

Another formal organization in the estate is the Salvation Army Neighborhood Center. It runs a day care center for children. Initially the center planned to run a drop-in center for residents but found it was not practical because of lack of manpower.

Community Life

The HDB community is not an undifferentiated mass as it consists of children, youth, working adults, housewives and the elderly. It is, however, the housewives and the elderly who are most estate bound.

On a typical day, the morning begins with school children and workers leaving for school or work. Then, between 8:00 a.m. and 10:30 a.m., streams of people of mixed ages, usually housewives and elderly women, gather at the wet market, the grocery shops or on stools just outside the hawker centers. This is the time when they catch up on the day's happenings. Very prominent is a group of women at the "neighborhood circle" in one of the neighborhoods.

They would usually meet every morning between 8:00 a.m. and 10:30 a.m. It is a mixed group ranging from those in their 50's to 70's. They do not meet in the afternoons because, for some, their children object to their spending so much time outdoors. Others say that they are usually busy in the afternoons.

It is also common to see the elderly stopping by the void deck to chat with others who may already be seated there. Another feature among elderly women is for them to clean their vegetables at the void deck. Usually two or three women gather together to clean their vegetables. Those who bring their grandchildren to the kindergartens usually do their cleaning in the void decks of the kindergartens.

While the women exchange information in front of shops/markets or in the neighborhood circle, the men seem to favor the hawkers or coffee shops in the neighborhood centers. This is where the proverbial coffee shop congregation takes place in which they discuss, over a cup of tea or coffee, political issues, make comments on the latest happenings in the country/community and catch up with developments among their family and friends. Other elderly men can be seen with their grandchildren at the void decks, either playing with them or keeping an eye on them while they play. While the women disappear into their homes by 11 a.m., the men usually are around until 12 noon, presumably going home for lunch then. They reappear again at about 3 p.m. and remain until 6:30 or 7 p.m.

Although the elderly make up the various groups in the void decks in the earlier part of the evening, the latter half sees the emergence of a younger group of people who join them. At night, youths take the place of the elderly at the void decks/playgrounds.

A very prominent group of elderly residents who appear both in the mornings and the afternoons are those who escort their grandchildren to the kindergartens every morning/afternoon. Some of them wait at the void deck while classes are going on, chatting with the other elderly residents or parents who might be there.

At every neighborhood center, usually in front of the coffee shops, is a bird rack. Every evening residents bring their birds down and hang them on the racks. Chairs are placed by the coffee shopowners around the bird rack and the owners of the birds, mostly men of mixed ages, ranging from as young as 10 years old to as old as 80 years, sit around and watch the birds. What is interesting about this group is that although most of them are regulars there and may acknowledge each other, they do not converse with each other, preferring instead to listen to their birds sing. This usually begins at about 5 in the evening and lasts up to approximately 8 at night.

Friendship Groups

The creation of void decks on the ground floor of every block was for a variety of purposes. While permission is granted to non-profit organizations to establish themselves in the void decks (e.g., kindergartens and child care centers) perhaps the most important purpose is to promote social interaction. At each corner of the void deck are stools, two tables and a bench. The tables have on them a chess board, which is why the playing of Chinese chess is a very common sight in the void decks. The availability of seats allows residents to stop for a rest on their way back from marketing or even a change of environment for those who are cooped up in their homes.

A study done by the HDB on the use of seats in void decks (Wong, 1985, p.389) showed that the void decks tended to be "colonized" by the elderly. The elderly tend to gather at the void decks at specific times, that is, from about 9 a.m. - 1 p.m. and from 3 p.m. - 6:30/7 p.m.

The regularity of the groups at the void decks, neighborhood squares and coffee shops enabled us to plot the various common gathering spots in the community as well as to observe the daily pattern of activities of the elderly in the community. What we noticed was that some of these groups were more organized in that they had a group of members who turned up regularly. A few members make up the core members of the group and others join them on a more ad hoc basis.

Although the majority of these friendship groups comprise the Chinese, among themselves they tend to group together in terms of dialect. For instance, the group at one block is made up entirely of the elderly belonging to the Hainanese dialect group. Very few of them speak any other dialects. What is really interesting about this group is that they have a very distinctive routine. Everyday between 8:45 and 9:00 a.m., the oldest lady in the group comes down and walks her dog in the void deck of a neighboring block and sits in the middle of a bench. A little while later, the other members in the group arrive and each of them occupies his/her own particular niche in the void deck, either on the floor or on the bench beside the old lady. By about 9:30 a.m., there are about five people, two of whom are men on their way back from the market. They stop by and chat about half an hour and then move on to their homes. Between 10:30 and 11 a.m., more women join the group so that by 11:30 a.m. the group swells to approximately eight people. They usually remain until a little after 12 noon when, one by one, they leave for home. The last to leave is the lady with the dog. The pattern is repeated almost every day. They obviously feel very comfortable in their corner. Once we observed one of the women drying her hair while the others were seated around her continuing their daily discussions. When it was dry she proceeded to comb it and tidied herself.

Other groups in other areas include a chess group whose members are mainly Hokkien speaking, a Teochew women's group, a Cantonese women's group, and a large group of elderly men who are also mainly Cantonese.

One of the women's groups that we studied in some detail has about 15 women whose ages range from 60 - 86 years. The bulk of the group members are in their 60's. At any one time, there are usually between 6 - 8 people in the void deck. They are not necessarily the same women every day. The group meets daily from 3 to 5 in the afternoons. They came together as a group quite unintentionally when some of the women, tired after the morning chores, would come down for a walk in the afternoons. As they kept bumping into each other quite frequently, they got acquainted and began to look forward to meeting each other at the void deck. Gradually, they began to meet regularly. Although they do know each other reasonably well, they do not make it a point to call each other at home, each preferring instead to meet at the void deck to catch up on the day's events.

Preliminary Survey Findings

Status of the Elderly

The status of the elderly, as captured in the survey, appears to be high. Table 1 shows the responses to two items: respect from family members and participation in family matters. It is clear that an overwhelming majority reported that they were respected by family members. The participation in family matters is also high, although the percentages decline with age, and for the widowed. It appears that the married and the 'young old' tend to be the group with the highest status at home.

Support Pattern

By and large, the respondents were well supported in the four items measured: daily task, emotional support, financial help, and emergency help. An overwhelming majority received financial help, with only about 5% not receiving help (Table 2). There is a slight sex difference, with the males tending to be the worse off. Further data analyses will be done to determine whether this is a genuine gender effect, or whether this is a function of age profile or response bias. It is interesting to note that emotional support is the most mentioned as being lacking. This could be a function of cultural disposition whereby emotional feelings are not readily expressed in oriental culture. There is a clear age effect on the help-receiving pattern: the older the respondent, the higher the likelihood of not receiving help. If more specific types of help are examined, it appears that help received in the performance of chores was most frequently mentioned (Table 3). Such chores might include child-minding, shopping, cooking, and housekeeping. Gifts and companionship were also important types of help received. On the whole, the level of help received, as measured by these specific items, was rather low. Does this contradict the positive findings reported above? The two are not contradictory, as the first finding includes those who do not need help. Moreover, the first measures a generalized level of perception which could be satisfied by one or many specific acts. The second finding is more specific and therefore the item by item response may be low.

Table 4 shows the help-giving pattern. The most common type of help provided by the aged respondents was financial help, followed by emergency help. The older respondents and the widowed were more likely to give help. We find this interesting, as one would expect the 'young old' and the married to be in a better position to offer help. We hypothesize that the 'young old' are probably still fairly active in their own affairs and may not spend as much time at home as their older counterparts. Table 5 shows the specific types of help provided to household members

The sources of help received are shown in Table 6. Sons were reported most frequently as the provider of help in daily tasks, financial help, and emergency help. Spouses were the most frequently mentioned in the case of emotional support. Further analysis will be carried out to control for the unavailability of helpers.

Table 7 shows the profile of help recipients. Friends and neighbors appear to be the main recipients of help provided by the aged. Neighbors particularly benefit in terms of emergency help, and friends, financial help. Two issues are involved in interpreting this finding. First, it needs to be ascertained whether ordinary assistance or wealth transfer provided to family members can be termed 'help' with all of its socio-emotive connotations. Second, it is recognized that friends and neighbors occupied specific positions in a person's emotive hierarchy, which invoke differential responses. Hence, it is not surprising that friends get more emotional help while neighbors get more emergency help and very little emotional help. The mapping of the emotive hierarchy is important to establish who is to give or receive what type of help.

Table 1
Status of Elderly at Home (Percentage)

		Respected by Family	Participate in Family Matters
Sex:	Male	97.2	81.9
	Female	97.4	81.4
Age:	60-64	98.5	91.7
	65 and over	96.4	73.8
Marital Status:	Single	75.4	50.0
	Married	98.4	87.6
	Separated/ Widowed	96.4	72.7

Table 2
Percent of Respondents Reporting Lack of Support by Type

	Total	Daily Task	Emotional Support	Financial Help	Emergency Help
Sex:					
Male	144	12.5	17.4	6.9	9.7
Female	156	3.9	12.8	3.9	1.3
Age:					
60-64	132	4.6	11.4	4.6	3.0
65 & over	168	10.7	17.9	6.0	7.2
Marital Status:					
Single	4	0.0	25.0	0.0	50.0
Married	186	8.6	11.8	5.9	4.3
Widowed/ Separated	110	7.3	20.0	4.6	5.5

Table 3
Percent of Respondents Receiving Help From Household Members by Type

	Gifts	Money	Care	House-Keeping	Accompany	Cooking	Shopping	Child-Minding
Sex:								
Male	26.4	11.8	7.6	14.6	34.0	13.9	32.6	31.9
Female	18.0	5.8	7.1	19.2	25.0	26.3	26.9	39.1
Age:								
60-64	21.2	11.4	7.6	18.2	25.8	25.0	28.0	32.6
65 & over	22.6	6.6	7.1	16.1	32.1	16.7	31.0	38.1
Marital Status:								
Single	50.0	50.0	25.0	25.0	75.0	25.0	50.0	50.0
Married	18.8	8.6	5.4	14.0	27.4	17.7	25.5	31.7
Widowed/ Separated	26.4	7.3	10.0	21.8	30.9	24.6	36.4	41.8

Table 4
Percentage of Respondents Reporting Giving Help to Others by Type

		Total	Daily Task	Emotional Support	Financial Help	Emergency Help
Sex:	Male	144	27.8	34.0	40.3	25.7
	Female	156	23.7	26.9	47.4	34.6
Age:	60-64	132	19.7	22.7	37.1	18.2
	65 & over	168	30.4	36.4	49.4	26.8
Marital Status:	Single	4	75.0	50.0	75.0	50.0
	Married	186	22.6	24.7	38.2	34.4
	Widowed/ Separated	110	29.1	39.1	52.7	22.7

Table 5
Percentage of Respondents Providing Help to Household Memebers by Type

	Gifts	Money	Care	House-Keeping	Accompany	Cooking	Shopping	Child-Minding
Sex:								
Male	50.7	52.8	35.4	52.1	63.2	63.2	59.0	31.4
Female	44.2	6.1	19.9	34.0	53.9	29.5	45.5	23.1
Age:								
60-64	38.6	55.7	17.4	34.1	50.8	40.9	42.4	22.0
65 & over	54.2	63.7	35.1	49.4	64.3	49.4	59.5	31.0
Marital:								
Single	25.0	25.0	50.0	50.0	50.0	25.0	50.0	50.0
Married	42.5	50.9	26.9	42.5	55.4	47.3	51.1	23.7
Widowed/ Separated	56.4	63.6	27.3	42.7	63.6	43.6	53.6	31.8

Table 6
Types of Help Received by Types of Helper (Percentage)

	Types of Helper						
Help Received:	Spouse	Son	Daughter	Daughter-in-law	Friend	Neighbor	Others
Daily Tasks	17.4	28.2	25.4	16.4	1.4	1.9	9.4
Emotional Support	30.3	24.2	23.6	5.5	9.1	1.2	6.1
Financial Help	4.9	67.8	21.9	0.6	0.6	--	4.4
Emergency Help	11.0	45.0	21.5	7.0	1.5	6.5	7.5

Table 7
Types of Help Given by Types of Helper
(Percentage)

	Types of Helper						
Help Received:	Spouse	Son	Daughter	Daughter-in-law	Friend	Neighbor	Others
Daily Tasks	7.6	13.6	11.9	17.0	16.1	28.0	5.9
Emotional Support	7.0	12.0	21.0	3.0	30.0	9.0	8.0
Financial Help	6.7	13.3	8.9	--	35.6	8.9	26.7
Emergency Help	2.3	12.4	10.1	11.2	16.9	31.5	15.7

Conclusion

The needs of the present elderly in Singapore are being met on two broad fronts. At the national level, the government is helping the elderly to be as self-reliant as possible through policy measures and formal services. Many of these are aimed at encouraging the family to take care of their dependent seniors. A number of voluntary and community human service organizations also provide assistance and services to help the dependent aged who are without benefit of family or kin support. Taken together, such measures go quite some way in allowing the majority to remain in the community and not be in residential care. This is as it should be.

Living in HDB estates has its advantages for the elderly. It has community facilities that the elderly can use, for example, void decks and senior citizens' corners. And many of the elderly do group together for companionship and social interaction, often times recreating the informal gatherings of village days. However, such social networks are not automatic features of urban living. Much depends on the willingness and efforts of the elderly to establish such links. Equally, informal social support among and for the elderly has to be consciously forged. The preliminary findings from the UNU study show that while the elderly are visible in the Clementi public housing estate with their social networks among neighbors and friends, not many consider themselves to have strong informal social support. It seems, for various reasons, the overlap between social networks and informal support is not extensive. In part, we surmise it could be because of the availability of a wide range of formal support, both from government and the voluntary sector. Another factor could be the relatively modest expectations of the present generation of the aged in terms of what they desire for a comfortable level of living.

Be that as it may, we think that the formal supportive mechanisms for the elderly are generally favorable and will show more positive effects in the future. However, at the individual level, whether his or her informal support system exists, is life enhancing or not, is something which has to be tackled separately.

References

Chong, Kim Chang, Wong Yew; Lim, Kok Leong; & Lim, Sah Soon. "Estate Management." In *Housing a Nation: 25 Years of Public Housing in Singapore*, pp. 263-334. Edited by Wong, Aline K. and Yeh, Stephen H.K. Singapore: Maruzen Asia for Housing and Development Board, 1985.

Housing and Development Board. *Annual Report 1986/87*. Singapore: The Board, NY.

Lim, Koon Poh; Moey, Hsiao Pi; Kwok, Kenson; Gan, Kok Tiong; Lim, Kin Hai; Seow, Simon; & Lee, Gek Ghoon. "HDB and Its Residents". In *Housing a Nation: 25 Years of Public Housing in Singapore*, pp. 375-408. Edited by Wong, Aline K. & Yeh, Stephen H.K. Singapore: Maruzen Asia for Housing and Development Board, 1985.

Ministry of Communications and Information. *Singapore 1987*.

Ministry of Health. *Report of the Committee on the Problems of the Aged.* Singapore. The Ministry, 1984.

Tan, Tony Keng Joo; Loh, Choon Tong; Tan, Sioe An; Lau, Woh Cheong; & Kwok, Kenson. "Physical Planning and Design." In *Housing a Nation: 25 Years of Public Housing in Singapore*, pp. 56-112. Edited by Wong, Aline K. & Yeh, Stephen H.K. Singapore: Maruzen Asia for Housing and Development Board, 1985.

Wong, Aline; Ooi, Goik Ling; & Ponniah, Rennis S. "Dimensions of HDB Community." In *Housing a Nation; 25 Years of Public Housing in Singapore*, pp 445-495. Edited by Wong, Aline K. & Yeh, Stephen H.K. Singapore: Maruzen Asia for Housing and Development Board, 1985.

Yeung, Yue-Man & Yeh, Stephen H.K. "A Review of Neighborhoods and Neighboring Practices." In *Public Housing in Singapore: A Multi-Disciplinary Study*, pp. 262-280. Edited by Yeh, Stephen H.K. Singapore: Singapore University Press for Housing and Development Board, 1975.

CHAPTER 16

THE IMPACT OF LIVING ARRANGEMENTS OF THE ELDERLY ON GOVERNMENT PROGRAMS IN THAILAND

Malinee Wongsith

Introduction

Thailand, along with Malaysia, Philippines, Singapore, and Indonesia, has been a participant in a four year study on the " Socio-Economic Consequences of the Aging of the Population", (SECAPT) 1984 - 1987, funded by the Australian Government. In each country a national survey of the elderly population (aged 60 years and over) was conducted to ascertain the socio-economic profile of the aged, their problems and needs. These countries individually and jointly reviewed the current situation of the elderly based on existing available information, gathered researchers with other relevant bodies to identify the areas of concern relating to the problems of the aged, reviewed and evaluated existing policies and programs affecting the elderly, and are now to discuss with policy makers the results of the survey: population projections, financial needs, family life, health care and other social needs of the elderly.

Development in Thailand has brought changes not only in technology but also in lifestyle and values, accompanied by a new trend in population distribution, with a steady decrease in the percentage of the population 15 years of age or younger and an increasing elderly population. A greater understanding is needed regarding these changes and the implications they have for defining national aging policies in Thailand and socio-economic implications for the country.

Thus, the purpose of the survey was to provide policy makers and planners in Thailand with key information regarding the present elderly population and its demographic patterns, attitudes, perceived needs, etc. This paper focuses on the family life of the Thai elderly. Their living conditions, roles and contribution to the community are investigated. Findings regarding the knowledge of and attitudes toward welfare programs are highlighted.

Background

In Thai society, old age begins at 60 years. Age is still computed in twelve year cycles, with the sixtieth birthday marking the completion of the fifth cycle. After reaching this age, a person is addressed by younger persons with special terms of respect, the equivalent of the kinship terms, "grandfather" or "grandmother," even though the speaker may not be related to the older person in any sense of kinship. In addition, 60 is the age of compulsory retirement throughout the civil service. Hence, 60 years and over is used to define the elderly in this study.

Thailand is currently experiencing a major decline in fertility, resulting in a recent reduction in the proportion of very young persons and a consequent increase in the proportion in older ages. The number of older people (aged 60 years and over) in Thailand has grown steadily from about 1.2 million in 1960 to 1.7 million in 1970, and 2.4 million in 1980. The estimated number of the aged in 1987 was about 3.1 million (5.8 percent of the total population) and it is projected to increase to 5.1 million (7.8 percent) in 2002.[1] With the prospect of further declines in fertility and increasing life expectancy, it is clear that the future will witness further aging of the population.

The proportion of the elderly in the Thai population grew slowly from an estimated 4.5 percent in 1960 to 5.4 percent in 1980; hence, old age has not been a serious problem in Thailand. However, an increase in the number and proportion of the aged population is anticipated during the next few decades and, combined with rapid socioeconomic, technological and cultural changes and the limited number of government programs available, this will undoubtedly create more of a burden to the society and particularly the poorest sector, whose families are least able to provide support for their aged members. In addition, the traditional privileged position enjoyed by the elderly, involving respect, consideration and status, is being eroded under the influence of modern trends. It is, therefore, time to examine and evaluate these changes and on that basis to formulate national policies and actions that will avoid some of the problems concerning the elderly now faced by many developed countries.

The Survey

This chapter reports on the findings of the SECAPT project, which collected baseline data on the current status and characteristics of the aged in Thailand. The main topics covered in the SECAPT survey were the demographic, socio-economic and health aspects of the elderly. The questionnaire for the aged consisted of 7 sections :

Section 1 - Household information. This section included a household record providing information on each household member and on the household's material possessions.

Section 2 - General background of the respondent. Information was collected on age, sex, birth date, marital status, language spoken, religion, education, number of children ever born, number of living children, and number of living siblings.

Section 3 - Employment. In this section, questions were asked about current and past employment, type of occupation, age at retirement, desire to work and attitude toward retirement.

Section 4 - Living arrangements and support. To obtain as complete a picture as possible of the level and nature of support that the elderly received, detailed information on support from and to each child was collected, together with main sources of income, the interviewee's living environment and the extent of social contacts.

Section 5 - Health. In this section, respondents were asked to assess their own health. Questions were also asked about specific health problems, ability to walk, see and hear, sources and cost of health care, and drinking and smoking habits.

Section 6 - Role and status of the elderly. Questions asked include decision-making in the household, inheritance patterns, activities performed in the household and in the community, and membership in social groups and clubs for older people.

Section 7 - General attitudes about the aged. The concept of being old, advantages and disadvantages of being elderly, type of welfare needed, and attitudes toward sex in old age were some of the questions asked in this section.

Sample Design[2]

The SECAPT was a nationally representative survey. A total sample of about 12,000 households from 99 clusters was designed originally to yield approximately 3,000 elderly and 1,500 adult (aged 15-44 years) individual interviews. During the first two weeks of the field work, it was discovered that the targeted number of 3,000 persons aged 60 years and over would not be achieved because the number of elderly per 100 households was lower than estimated. The sample size of SECAPT was therefore expanded to include additional households in 36 clusters originally prepared for additional purposes. This yielded a total of more than 17,000 sample households from 135 clusters. For the elderly sample, all households in the sample village/ blocks were theoretically to be visited, while the adult sample would be determined by an appropriate sampling interval. In general, the total number of households in a village/block selected for the adult survey was roughly equal to one-half of the number of eligible elderly identified in the area.

The sample was designed to provide self-weighting estimates at the national level as well as for urban and rural populations. Due to the differences in the replacement level of households and response rates, the national results were obtained by appropriately weighting the results. Sample cases were weighted to make the urban-rural distribution of the sample correspond to the expected distribution according to the 1984 Survey of Population Change (SPC). In this paper only the weighted numbers of cases are reported.

Characteristics of the Elderly Respondents

A short description of the socio-economic and demographic characteristics of the elderly respondents provides a background for interpretation of the findings presented here.

The SECAPT is based on interviews of 3,252 persons aged 60 years and over, of whom 1,330 were males and 1,922 were females. Almost half of the elderly (45 percent) are in the 65-74 year age group. The high number of non-responses among the very old (75 years and over) due to health problems reduced the percentage of this age group in the total.

More than half of the elderly are married, and another two-fifths of them are widowed. Nearly two percent are divorced or separated and only one percent of elderly are single. The marital status of males and females is different. Most of the older men were married (78 percent) while 58 percent of the elderly females were widowed.

Only 38 percent of the elderly report that they work for pay (gainful worker concept). Most of the elderly are engaged in agriculture.

Nearly half of the elderly have no education and cannot read or write. The proportion of the elderly with no education is higher in rural than urban areas. Males have more education than females. Almost half of the elderly receive their income from their children. Work appears to be the second most important source of their income.

The vast majority of the aged (90 percent) are Buddhists and about 9 percent are Moslems. The remainder are Christians, animists, and those with no religion.

Household structure

Living arrangements of the elderly in developing countries varies from those in developed areas. In agricultural societies, the predominant family structure is the extended family, consisting of more than two immediate generations living together. In contrast, the nuclear family predominates in the industrialized societies.

THE IMPACT OF LIVING ARRANGEMENTS OF THE ELDERLY ON GOVERNMENT PROGRAMS IN THAILAND

The traditional norm of Thai households is the extended household containing two generations or more. As such, the elderly live with their children and get support from them while helping with household chores such as cooking, housekeeping, child raising, etc. Due to social and economic changes in Thailand, many newly-wed couples now have their own residence and thus live in nuclear households. This change has affected the daily living of the elderly as well. As Table 1 demonstrates, most older people do not live alone or even with non-relatives; they live in either nuclear or extended households. Still, it is found that more than half of the elderly, 57 percent, reside in a stem household (a household which is composed of husband and/or wife with one married child or niece, and possibly with unmarried children or other relatives in the same generation as the children). Thus, most of the aged live with their children. When present age is taken into consideration, the older the individual, the higher the percentage of those residing in stem households.

The percentages of those aged 60-64, 65-74 and 75 years and over residing in stem households are 50, 57 and 66 percent, respectively. In contrast, 40 percent of those who are 60-64 years of age reside in nuclear households. The proportion declines in the higher age groups to 31 and 21 percent for the 65-74 and 75+ age groups. Probably one of the most important reasons is the health status of the elderly; the need of older people for assistance makes them dependent on their children. The older the person, the greater the amount of care needed. In some cases, the children have to move back to take care of their elderly parents. This pattern reflects the role of the extended household in providing services to the elderly.

Table 1
Percent Distribution of the Elderly According to Household Structure, by Selected Background Characteristics

Background Characteristic	One person household	Nuclear household	Stem household	Joint household	Stem-Joint House-Hold	Other	Total	Weighted N
	Household Structure							
Age								
60-64	2.1	40.1	50.2	1.6	5.7	0.3	100	1,081
65-74	5.1	31.1	57.0	1.8	4.7	0.3	100	1,466
75+	6.6	20.6	65.5	1.9	5.0	0.4	100	705
Sex								
Male	3.6	39.2	51.2	1.4	4.6	0.0	100	1,333
Female	5.1	26.7	60.3	1.9	3.5	0.5	100	1,919
Urban-rural residence								
Urban	3.6	32.5	48.8	4.1	10.3	0.7	100	561
Rural	4.6	31.7	58.2	1.2	4.0	0.2	100	2,691
Total	4.4	31.8	56.6	1.7	5.1	0.3	100	3,252

The living arrangements of the elderly in the urban and rural areas are very similar. The proportion of the aged residing in stem households is slightly higher in rural than urban areas. The proportion of the elderly living alone in the rural areas is higher in every age-group than in urban areas and the percentage increases with age, indicating that this group should be studied to determine the means and adequacy of care.

It has been noted that within the structure of the household and its arrangements, more elderly men than woman tend to live with their spouses, the proportion decreasing with age (Andrews et al., 1986). A similar pattern is found in this study; women live alone more than men for several reasons, including the fact that widowed women seldom remarry while there are many opportunities for widowed men to marry younger women. Thai women tend to outlive men and the difference in life expectancy, and thus in the number of widows, results in a higher percentage of single households among elderly women. Thai men generally remain married to the end of their lives. The advantage for men is sizable, because the wives are the primary source of emotional and practical support among the married elderly (Kendig & McCallum, 1986).

Considering living arrangements in a broader context involves three aspects related to the status of the elderly. High status tends to be associated with the position of head of the household, with house and land ownership and with precedence in household decision-making. In interpreting the data, it should be noted that the responses are those of the elderly and they reflect self-judgment on their part.

Table 2
Percent Distribution of the Elderly According to Relation to Head of Household, by Selected Background Characteristics

	Relation to head						
Background Characteristic	Head of Household	Spouse	Parent	Other Member	Other	Total	Weighted N
Age							
60-64	60.1	28.8	9.4	1.6	0.0	100	1,081
65-74	58.5	17.3	21.8	1.9	0.4	100	1,466
75+	47.1	6.6	43.6	2.5	0.2	100	705
Sex							
Male	85.0	1.4	12.0	1.3	0.3	100	1,333
Female	36.8	30.9	29.7	2.4	0.2	100	1,919
Urban-rural residence							
Urban	49.4	15.7	29.5	5.0	0.5	100	561
Rural	58.1	19.5	21.0	1.3	0.2	100	2,691
Total	56.6	18.8	22.4	1.9	0.2	100	3,2

The percentage of elderly who are heads of households is higher than for other indicators of status (Table 2). This percentage declines with increasing age. Sixty percent of the elderly aged 60-64 years are heads of households, the proportions decreasing to 59 and 47 percent, respectively, for the aged-group 65-74 and 75 years and over. The reduction of the proportion of elderly heads of household indicates that the status of the elderly tends to decline with age, due partly to the fact that the elderly are the less economically active, hence no longer maintaining the same authority in this sphere. This erosion in authority and stature can have an impact on the relationship between the elderly and the rest of the household.

The difference in proportion of household heads between male and female is large; 85 percent of the elderly males are heads of households, compared with 37 percent of the females. Thirty-one percent of females are spouses of heads of households. The percentage is higher in rural areas, where the extended family predominates. Normally the elderly have power and authority over the younger generations. Important decision-making and serving as consultants are tasks of the elderly. However, it should be kept in mind that while most of the elderly are the head of households, they are not necessarily the main breadwinners of the households. In many cases, being designated head of the household is only a symbol of respect for old people.

In developing countries, particularly in the rural areas, the aged can make major economic contributions as the owner of the land, houses or other property (Kendig, 1987). Usually, household property is under the control of the head of the household. Table 3 shows that most of the elderly or spouses are the owners of residences. The percentage of ownership by the elderly declines with age. For those aged 60-64, 65-74 and 75 years and over, the percentages of house owners are 89, 81 and 69, respectively. Those who are not house owners tend to live in the homes of their children, more so in rural than urban areas, while a higher percentage of the urban elderly live in houses owned by other household members, or in rented or government housing.

Table 3
Percent Distribution of the Elderly According to House Ownership by Selected Background Characteristics

	House Ownership					
Background characteristic	Self/ spouse	Children	Other member	Rent/ government	Total	Weighted N
Age						
60-64	89.2	4.7	2.3	3.8	100	1,078
65-74	80.5	11.3	4.6	3.7	100	1,455
75+	68.6	21.3	7.1	3.0	100	692
Sex						
Male	85.9	7.3	3.0	3.8	100	1,325
Female	77.3	14.0	5.3	3.4	100	1,900
Urban-rural residence						
Urban	54.1	20.3	9.4	16.2	100	557
Rural	86.4	9.3	3.3	0.9	100	2,668
Total	80.9	11.2	4.4	3.5	100	3,225

Apart from house ownership, which indirectly indicates the power of the elderly over the other household members, Thai elderly (especially in the rural areas) are reported to have very high status. They can maintain positions of authority as heads of joint households (Cowgill, 1968). The joint households of several generations, and in some cases the proximity of a much broader family in "compounds" or other clusters of dwellings, also facilitate the role of the elderly as providers of child care and education and enable them to keep in close touch with important family decisions (Kendig, 1987). Based on tradition, older people have authority because of their knowledge and advice. They have the final decision-making as summarized in Table 4, which identifies the persons who usually make the final decisions in major issues such as buying or selling land, proposed migration of family members, etc.

The study reveals that one-half of the elderly usually made the final decisions on important matters. This percentage varies with age; as age increases, the percentage of the elderly who make the final decisions decreases. With advanced age, decision-making shifts from the elderly, themselves, to their children. Forty-two percent of those aged 75 years and over mentioned that the final decisions in the household were made by children. Another factor is the health status of the elderly, for the very old may be limited in the kinds and amount of activity they can undertake, with some totally unable to carry out the major activities of daily living. In this case their children take a more important role.

Table 4
Percent Distribution of the Elderly According to Household Decision Maker by Selected Background Characteristics

	Decision Maker							
	Together	Self	Spouse	Children	Daughter & son-in-law	Other	Total	Weighted N
Age								
60-64	5.4	55.9	20.4	13.9	2.6	1.7	100	1,075
65-74	3.6	51.3	12.2	25.2	5.7	1.9	100	1,455
75+	4.4	37.0	6.1	42.0	8.8	1.7	100	688
Sex								
Male	4.4	70.8	6.8	14.2	2.5	1.3	100	1,320
Female	4.3	35.1	18.4	32.6	7.3	2.2	100	1,898
Urban-rural residence								
Urban	4.6	45.9	11.7	29.0	5.1	3.6	100	554
Rural	4.3	50.6	14.0	24.2	5.4	1.5	100	2,664
Total	4.4	49.8	13.6	25.0	5.3	1.8	100	3,218

Sex and residence also influence decision-making, as 71 percent of the elderly men said they make the final decision while only 35 percent of the women did so. Rural elderly tend to be decision makers more than their urban counterparts.

Daily living

As mentioned earlier, most of the elderly live with children or relatives. More than half of them bear at least their proportional share of the households costs. The potential benefits of multi-person households which involve a spouse or one's relatives are well known. There are strong motivations for forming family units simply on the basis of productivity (Viscusi, 1981). Household activities can often be done individually or on a joint basis. Several forms of in-kind assistance can be provided by the elderly. The nonelderly relatives get benefits in a variety of ways from the elderly through gardening, cooking, buying food and other activities as summarized in Table 5. The diverse and widespread nature of this assistance indicates that the elderly at least contribute in the provision of services to the other members through the performance of household chores.

The major day-to-day activities of the elderly are listed in Table 6, led by walking and followed by taking care of animals and watching television. It should be noted that "walking" in this context does not mean for exercise. Most of the Thai, especially in rural areas, referred to "walking to neighbors or relative's houses and chatting with them." As over 75 percent of the Thai population are engaged in agriculture, it is not surprising that 44 percent of the elderly reported that they regularly participated in taking care of animals. With overall rapid development, the exposure to mass media such as television and radio appears to have increased.

Table 5
Percent Distribution of the Elderly According to Persons Who Did Household Chores

Household chores	Persons who did household chores							
	Self	Other	Every one	Servant	No chore	Non-member	Total	Weighted N
Gardening	22.7	32.2	20.3	0.3	24.2	0.1	100	3,222
Cooking	21.4	62.2	14.0	0.5	1.4	0.5	100	3,223
Buying food	19.2	68.4	9.3	0.3	2.1	0.7	100	3,223
House cleaning	18.6	51.3	28.4	1.0	0.5	0.3	100	3,223
Buying h.h.items	17.6	69.0	10.7	0.2	1.8	0.6	100	3,223
Laundry	11.8	59.4	25.5	1.5	1.3	0.4	100	3,223
Taking care of children	10.2	17.6	17.2	0.3	54.4	0.2	100	3,223

Table 6
Percent Distribution of the Elderly According to Frequency of Activities

Activities	Frequency of Activities					
	Regularly	Sometimes	Rarely	Never	Total	Weighted N
Walking	56.3	21.8	9.2	12.7	100	3,220
Take care of animals	43.9	9.7	4.4	42.1	100	3,219
Watch t.v.	30.2	19.3	12.0	38.5	100	3,223
Listen to radio	27.4	23.1	16.0	33.5	100	3,223
Cooking	24.4	18.8	14.8	42.0	100	3,222
Play with children	23.2	19.3	8.4	49.1	100	3,223
Gardening	21.7	16.1	14.3	47.9	100	3,222
Reading	14.8	8.7	8.6	68.0	100	3,221
Weaving, sewing	10.3	10.3	11.0	68.5	100	3,220
Exercise	1.0	0.4	0.2	98.4	100	3,223
Carving	0.9	0.4	0.3	98.3	100	3,215
Playing cards	0.7	1.0	1.3	98.0	100	3,220

The least frequently mentioned activities are card playing, exercise and carving. Reading also is an infrequent activity, influenced by the low literacy rate of the elderly and the existence of optical problems.

Table 7
Percent Distribution of the Elderly According to Consultant Status on Household Matters, by Selected Background Characteristics

	Ever been consulted				
Background characteristic	Yes	No	Live alone	Total	Weighted N
Age					
60-64	73.1	24.8	2.1	100	1,073
65-74	64.9	30.0	5.2	100	1,457
75+	54.2	39.1	6.7	100	692
Sex					
Male	73.1	23.3	3.6	100	1,322
Female	59.9	35.0	5.1	100	1,900
Urban-rural residence					
Urban	66.1	30.2	3.7	100	554
Rural	65.1	30.2	4.7	100	2,668
Total	65.3	30.2	4.5	100	3,222

It is generally accepted that the status of the elderly is relatively high in Thailand. Young persons respect and support the elderly and the elders serve as the cornerstone of the family. Their presence contributes to the effective functioning of the family unit both through taking over some household duties and through the role as family consultant on important matters. Younger persons pay special heed to the advice and counsel of the elderly. Major family decisions almost always require the wisdom of years through suggestions and comments of the elderly. The findings in Table 7 confirm this role, but show that as age increases the percentage who are consulted declines, and fewer women than men report giving advice.

Intergenerational relations

An important aspect of socio-economic change in developing countries is its effect on intergenerational relations. Families typically exchange help along generational lines. Help may take the form of visiting, financial assistance, services, gifts, advice and counseling and other aid. These may be extended periodically, on ceremonial occasions or during time of crisis. (Birren & Woodruff, 1975). Generally, adjacent generations maintain the closest relations, especially those who live with the aged. However, the aid and contact are by no means restricted to those living in one household, as visiting and mutual assistance occur frequently, characterized as "intimacy at a distance." The only problem is that the relationship may be severely impaired if the children live too far away (Rosenmayer, 1972). Interaction with the elderly depends not merely on bonds of affection but also on financial constraints to visiting and the extent of other responsibilities and competing social or recreational interests (Treas, 1975).

Not all children are in close contact with their parents, but daughters keep in touch more than sons, unmarried more than married, own children more than in-laws, and children living close by more than those further away, (Treas, 1975). In Thailand, 46 percent of the elderly receive visits from their children every day. (Table 8). There are no age and sex differentials in the daily visiting by the children but a higher percentage of rural elders were visited every day by their children than were their urban counterparts. In large part this is due to the common practice, especially in rural areas, of a young couple starting a family to set up their own household near the wife's parental home. The tight housing problem in urban areas may force newly-weds to live far away from the parents, making everyday visits difficult. A very small percentage of the elderly report no visits by their children.

Although the percentage of those who never visit their children suggests more restricted mobility on the part of the elderly (15 percent compared with 3 percent of the children), significant percentages of the elderly visit daily or often (Table 9). Again, age is inversely related to the number of visits. For those 75 years and over, 24 percent never visit their children as compared to 12 percent of those aged 60-64 years. Visiting children depends not only on financial ability but also on good health, especially for those whose children live far away.

The frequency of visits between older persons and their children tells nothing about the quality of family relations. It is not known whether the visits are warm or only a necessary formality. However, they do indicate a sense of family responsibility for the elderly.

Table 8
Percent Distribution of the Elderly According to Frequency of Children's Visits, by Selected Background Characteristics

	Frequency of visit							
Background characteistic	Never	Every day	Often	Once in a while	No children living elsewhere	Single	Total	Weighted N
Age								
60-64	2.5	47.1	33.2	6.4	7.5	3.3	100	1,078
65-74	3.1	47.0	32.2	7.1	6.6	3.9	100	1,455
75+	3.3	43.8	34.2	8.0	7.0	3.5	100	693
Sex								
Male	3.3	45.3	35.0	6.8	6.1	3.5	100	1,324
Female	2.7	47.1	31.6	7.2	7.6	3.7	100	1,902
Urban-rural residence								
Urban	5.2	23.5	44.7	9.3	11.1	5.9	100	556
Rural	2.5	51.1	30.6	6.6	6.1	3.1	100	2,670
Total	3.0	46.3	33.0	7.1	7.0	3.6	100	3,226

Table 9
Percent Distribution of the Elderly According to Frequency of Visits to Children, by Selected Background Characteristic

Background characteristic	Frequency of visit							
	Never	Every day	Often	Once in a while	No children living elsewhere	Single	Total	Weighted N
Age								
60-64	11.6	34.6	29.2	13.9	7.4	3.3	100	1,079
65-74	14.0	35.0	27.2	13.1	6.7	3.9	100	1,453
75+	23.7	26.6	25.9	13.4	7.1	3.4	100	690
Sex								
Male	13.0	32.2	32.1	13.2	6.1	3.5	100	1,325
Female	16.9	33.6	24.5	13.6	7.7	3.7	100	1,895
Urban-rural residence								
Urban	24.6	14.8	23.7	19.6	11.1	5.9	100	556
Rural	13.3	36.9	28.4	12.2	6.2	3.1	100	2,665
Total	15.3	33.1	27.6	13.4	7.0	3.6	100	3,221

Furthermore, the linkages between the elderly and their families can be seen in the extent to which support is provided by children. Living near their children is no guarantee that the elderly will receive support, but 97 percent said they had received care or support from at least one child. This finding documents the fact that most older persons have children who assist in their care. Although the percentage is relatively small (6.4 percent), the elderly who are single or who have no living children are also in need of care and support which must be provided through other sources. That the need is prevalent is indicated in Table 10. Again a positive relationship with age is seen, and the need is greater among women and in rural areas.

Table 10
Percent Distribution of the Elderly According to the Need of Care and Support from Children, by Selected Background Characteristics

	Need for care and support				
Background characteristic	Need	No need	Depends	Total	Weighted N
Age					
60-64	87.1	11.4	1.5	100	2,041
65-74	89.0	9.5	1.5	100	1,402
75+	91.5	6.2	2.3	100	672
Sex					
Male	86.2	12.0	1.8	100	1,280
Female	90.8	7.6	1.6	100	1,835
Urban-rural residence					
Urban	81.0	16.0	3.0	100	523
Rural	90.5	8.1	1.4	100	2,592
Total	88.9	9.4	1.7	100	3,115

The extent to which the elderly who need support from their children can expect to receive it is influenced by a number of factors. The relatively rapid decline in Thai fertility has brought about a small family norm. With a smaller number of children, the burden of providing care for the elderly parents becomes heavier as fewer children share the responsibility.

There are other continuing changes in Thai society that are altering the relations between older and younger generations. Farming is no longer the most attractive way to make a living, as there is a shortage of land and income is unpredictable. With more job opportunities in the big city, many of the young move to Bangkok to take jobs as unskilled laborers. Some return to their villages during harvest season while others work only in the city. Under these circumstances, there is a shortage of field laborers leading to low productivity in the rural areas. Many elderly are left behind to care for small children, but most of those whose children work elsewhere say they do not feel the lack of a caretaker (Table 11). Need for a caretaker is reported by 25 percent of the 60-64 age-group, and 21 and 16 percent of those 65-74, and 75 years and over. The percentage of rural elderly who felt there was no one to take care of them is much higher than among urban residents, reflecting the limited job opportunities and uncertainties associated with rural economic development which have stimulated rural-urban migration of young workers.

Table 11
Percent Distribution of the Elderly Whose Children Work Elsewhere According to Feeling of Lack of a Caretaker, by Selected Background Characteristics

Background characteristic	Yes	No	Total	Weighted N
Age				
60-64	25.0	75.0	100	416
65-74	20.5	79.5	100	451
75+	16.1	83.9	100	175
Sex				
Male	25.5	74.5	100	470
Female	23.4	76.6	100	571
Urban-rural residence				
Urban	14.6	85.4	100	156
Rural	26.1	73.9	100	886
Total	21.6	78.4	100	1,042

Table 12
Percent Distribution of the Elderly Whose Children Work Elsewhere According to Feeling of Being Neglected, by Selected Background Characteristics

	Feeling of being neglected			
Background characteristic	Yes	No	Total	Weighted N
Age				
60-64	24.8	75.2	100	416
65-74	24.4	75.6	100	447
75+	18.5	81.5	100	175
Sex				
Male	22.2	77.8	100	469
Female	24.6	75.4	100	569
Urban-rural residence				
Urban	15.8	84.2	100	156
Rural	24.9	75.1	100	882
Total	23.5	76.5	100	1,038

Even though the out-migration of the young should not be taken as abandonment of the elderly, many older persons do feel neglected. While Table 12 shows similar patterns of the feeling of lack of a caretaker, a higher percentage of females express a feeling of neglect. Approximately one-fifth of the elderly feel neglected and further study is needed to determine the factors involved.

In Thailand it is common to find two or three generations living together in the same household. Such living arrangements are beneficial due to heavy reliance on family members for productive and remunerative activities, but troublesome because of the intergenerational conflicts which may occur. As has been noted in major studies of kinship structure in developing countries, most older people are generally respected and supported by the young, having at least one child. (Cantor, 1987).

Table 13
Percent Distribution of the Elderly According to Problems of Living with Children, by Selected Background Characteristics

	Problems						
Background characteristic	None	Conflict with children	Disobedience	Other	Not live together	Total	Weighted N
Age							
60-64	77.7	0.3	7.7	4.9	9.4	100	1,069
65-74	73.9	0.9	7.2	4.2	13.7	100	1,452
75+	76.6	0.6	5.9	3.6	13.4	100	688
Sex							
Male	75.6	0.4	4.9	4.9	14.2	100	1,314
Female	75.9	0.8	8.6	3.9	10.9	100	1,895
Urban-rural residence							
Urban	75.5	0.7	8.8	4.3	10.7	100	554
Rural	75.8	0.6	6.7	4.3	12.5	100	2,655
Total	75.7	0.6	7.1	4.3	12.2	100	3,209

In residing together, a proper relationship among generations is expected. The young provide care and support for the elderly while the latter perform various household functions (see Table 5) or, in some cases, may even find it necessary to take in and endeavor to support incapable adult children. Living under the same roof is also more likely to create problems. The study shows that 88 percent of the Thai elderly live with children (Table 13) and 76 percent say they have no problems. It is possible that this is the situation, but it is traditional for most of the Thai elderly to avoid telling outsiders about household conflicts or related matters. A Thai proverb says "do not take out fire from home and do not bring in fire from outside." (Fire in this case means problems). This reticence undoubtedly contributes to the low figure of 8 percent who admit experiencing conflicts and problems of disobedient children.

In summary, most of the elderly in Thai society live in extended households. Thai women in rural areas are more likely to be found living alone due largely to greater longevity and less opportunity to remarry. Most of the elderly are household heads and own their own homes. At the same time they admit that they need care and support from their children.

Role and contribution of the elderly in the community

A community is defined as an area of residence which has an informal character and some primary interpersonal relations derived from familiarity, common residence and a general concern for the locality (Plange, 1987). In this sense, the village is the community in rural areas while in the urban setting the neighborhood is identified as such. In this study, the role and contribution of the elderly in the community are measured by the extent and the nature of their activities.

In Thailand, children, adults and old people are regarded differently and each group has an appropriate pattern of expected behavior. Age is still a basic determinant of status in the society (Cowgill, 1967). The elderly generally receive high respect for their many experiences. Some elderly in this culture have respected roles as wise counsellors or village leaders. Nearly 5 percent of the elderly interviewed in this study have positions in the community such as Kamnan, village heads, members of village councils, village public health personnel or persons who manage temples.

Along with the position of the elderly in the community, participation of the elderly in groups or associations is quite interesting. Most of the elderly (over 90 percent) are not members of various groups (Table 14). Religious groups seem to be the only group that get more members, either with or without position. The very low percentage of the elderly who are members of religious groups does not imply that Thai elderly are less religious. The temple in Thai society serves as a social center for the community, offering a variety of social events and support groups that can enmesh a person in a comfortable network of acquaintances. This function is evident for the elderly. They go individually to the temple for visits, making merit or performing religious ceremonies, etc. These do not require joining a group, as Thai Buddhism emphasizes the role and responsibility of the individual. If they go to the temple with others, it is a matter of social preference or convenience, and religious participation is on an individual basis.

Table 14
Percent Distribution of the Elderly According to Membership and Positions in Each Type of Group

	Membership and position				
Type of group	Yes, with position	Yes, without position	No	Total	Weighted N
Religious	2.9	3.7	93.4	100	3,217
Recreational	0.8	2.4	96.8	100	3,218
Aid	0.4	1.3	98.3	100	3,210
Political	0.1	0.2	99.8	100	3,218
Occupational	0.9	4.4	94.8	100	3,218

Much of the research suggests that religious affiliation and church attendance increase with age, especially in agrarian societies where religion tends to be pronounced among older people (Weeks, 1984). In this study (Table 15) it was found that one third of the elderly go to the temple on every important religious day. As age increases, the frequency of going to the temple seems to decrease, especially for those age 75 years and over, perhaps due to health deterioration. Furthermore, there is no sex difference in the frequency of going to the temple, but rural elderly are more likely to go than their urban counterparts. Those who have never gone to the temple account for 26 percent in urban areas but only 13 percent in rural ones.

Table 15

Percent Distribution of the Elderly According to Frequency of Temple Attendance, by Selected Background Characteristics

Background characteristic	Frequency of going to temple								
	Every day	Every week	Every important religious day	Sometimes	Hardly ever	Never	Every month	Total	Weighted N
Age									
60-64	7.3	17.7	38.9	16.0	8.3	8.4	3.5	100	1,075
65-74	6.2	18.6	35.4	14.9	9.6	12.4	3.0	100	1,456
75+	4.8	15.7	27.3	10.2	9.7	30.0	2.3	100	690
Sex									
Male	6.3	17.3	33.3	15.7	10.2	13.4	3.9	100	1,321
Female	6.2	17.9	35.9	13.2	8.5	15.8	2.4	100	1,899
Urban-rural residence									
Urban	2.3	11.9	28.7	15.8	13.9	25.6	1.7	100	554
Rural	7.1	18.9	36.1	13.9	8.2	12.6	3.2	100	2,666
Total	6.3	17.7	34.8	14.2	9.2	14.8	3.0	100	3,220

Table 16
Percent Distribution of the Elderly According to Community Activities Participation, by Selected Background Characteristics

Background characteristic	Community activities participation				
	All	Some	None	Total	Weighted N
Age					
60-64	19.8	68.2	11.9	100	1,076
65-74	14.5	72.2	13.3	100	1,457
75+	10.6	69.1	20.3	100	691
Sex					
Male	19.5	67.6	12.8	100	1,322
Female	12.6	72.0	15.4	100	1,901
Urban-rural residence					
Urban	10.2	68.0	21.8	100	555
Rural	16.5	70.7	12.8	100	2,668
Total	15.4	70.2	14.4	100	3,223

In both rural and urban settings the elderly participate in community activities (Table 16). Their participation occurs more frequently in rural villages than in urban neighborhoods. Because the elderly in Thai villages are treated with respect and still remain important in decision making, many village committees which supervise various activities include quite a few elders. Their long experience and seniority give them a significant participatory role. The elderly often play ceremonial roles and are consulted on traditional issues and prominent ceremonies. For example, traditionally only elderly persons pour lustral water over the hands of the bride and groom at a Thai wedding. Thus,the frequency of participation by the elderly in the community or village activities contributes to their general status in the community and to their status within the extended family.

Of those who have ever joined the community or village activities, most (68%) joined the activities without any formal position (Table 17). Twenty-one percent were members and the rest were committee members or local leaders. Actually, these elderly are selected either on the prominence of their previous leadership or by their own charismatic qualities.

Table 17
Percent Distribution of the Elderly Who Participate in Community Activities According to Joining Status, by Selected Background Characteristics

	Joining status						
Background characteristic	No status	Local leader	Committee member	Member	Other	Total	Weighted N
Age							
60-64	65.2	1.8	9.2	21.3	0.1	100	947
65-74	68.5	2.2	11.6	20.5	0.2	100	1,262
75+	69.0	2.7	8.6	21.9	-	100	549
Sex							
Male	61.1	3.9	14.0	20.8	0.2	100	1,150
Female	72.1	1.0	5.7	21.2	0.1	100	1,608
Urban-rural residence							
Urban	65.5	2.2	18.1	14.0	0.2	100	1,150
Rural	67.9	2.2	7.5	22.3	0.1	100	2,324
Total	67.5	2.2	9.2	21.0	0.1	100	2,758

Considerable insight into the type of contribution to the community (Table 18) can be seen. There are certain kinds of activities traditionally more appropriate for elderly men or women. Thais feel that the elderly should engage in making merit and 37 percent of the aged reported doing so. Making merit in the Thai sense is to perform deeds or take action that benefit the individual in this life or the next.

Hence, it covers a wide range of activities. For example, elderly women provide food for the priests and clean and care for the temple, elderly men enter priesthood briefly, donations are made in cash or in kind to the temple or to poorer people, and birds or fish are released. With this belief, over one-third mention making merit as appropriate contributions of the elderly to the community. Women are more active in making merit than men but less likely to participate in other activities.

Table 18
Percent Distribution of the Elderly According to Types of Contribution to the Community, by Selected Background Characteristics

	Types of Contribution									
Background characteristic	None	Make merit	Train youngsters	Occupational training	Pass on experience	Help development	Every thing	Other	Total	Weighted N
Age										
60-64	27.9	38.4	13.6	1.3	6.7	5.7	2.4	4.1	100	940
65-74	34.2	35.8	13.0	1.0	4.1	4.4	3.0	4.5	100	1,287
75+	48.0	36.0	6.7	0.7	3.1	1.1	1.5	2.7	100	600
Sex										
Male	27.8	31.2	17.7	1.5	7.4	7.5	2.7	4.2	100	1,208
Female	40.5	40.8	7.5	0.7	2.7	1.6	2.3	3.8	100	1,619
Urban-rural residence										
Urban	35.7	37.5	11.2	1.5	4.5	2.1	3.7	3.8	100	467
Rural	34.9	36.5	12.0	0.9	4.8	4.5	2.2	4.0	100	2,360
Total	35.1	36.7	11.9	1.0	4.7	4.1	2.5	4.0	100	2,827

Old age experiences also seem to be valuable. Twelve percent of the elderly want to train youngsters, while about 9 percent prefer to pass on their experience or help in development.

It should also be pointed out that 35 percent of the elderly report that they have nothing to contribute to society. This may be due to their understanding of "contribution" in the limited terms of physical function such as building a road or digging a well. Thus, those who are not physically able or have no financial resources may feel that they have nothing to contribute.

Finally, although most Thai elderly are not members of any particular group, the majority still participate in community activities. The main task of those who are concerned with the aged is to arrange social activities which are appropriate for the elderly.

Existing Welfare Programs

In general, Thailand still relies heavily on the family system to provide the major portion of care and support for the elderly. Only recently has the aging population received some attention from the government. In 1982, the government set up the National Committee for the Elderly. A long-term plan for the elderly (1982-2001) was drawn up by the sub-committee of Research and Long Term Planning for the Aged. This plan dealt with five aspects of aging: health, education, income, and employment warranty, social and culture aspects, and social security.

Presently the support and care of the elderly in Thailand remains primarily with the family and depends also on the effectiveness of its intricate networks. These may include and involve kin who are immediate members of the household and also those outside the household. Only when family or other relatives are unavailable do the elderly turn to the community for assistance, followed by efforts to obtain help from government and private services. Government and private services in Thailand are still limited in number and scope and description of these programs follows.

Government programs

Welfare programs provided to the elderly by the government are both institutional and non-institutional. Most of the programs for the elderly are the responsibility of the Department of Public Welfare and the Ministry of Interior, with some supportive programs carried out by the Department of Medical Service, Ministry of Public Health and the Department of Non-formal Education, Ministry of Education.

Homes for the elderly [3]

The Department of Public Welfare has operated homes for the elderly since 1953 with the main purpose of rendering residential care to needy persons who meet the requirements: over 60 years of age for females and over 65 years for males, homeless, no relatives to live with or unable to live happily with their own families. The services provided include lodging and food, clothing, personal and therapeutic activities for physical rehabilitation, recreational activities, traditional festival activities, social work services, and traditional funeral services. Hobbies and vocational therapeutic activities are arranged, such as embroidery, handicrafts, etc. The Department maintains four types of facilities:

1. Free-of-charge: for the elderly persons with no means of support. This program is available in all of the homes for the elderly.

2. Hostel-type: for the elderly who can afford a monthly charge for living quarters at a rate of 550 baht (US $22) for a single room and 1,060 baht (US $42) for a double room.

3. Private house: for elderly persons who are financially able to own their own houses built in the compound of the institution and conforming to the housing designs of the Department. These houses will automatically become the property of the Department of Public Welfare after the death of the owner and his spouse.

4. Holiday home: two holiday homes have initially been built for the elderly with the cooperation of the Provincial Authority. They provide opportunities for older persons to relax and vacation at a seaside resort.

Local resources are also mobilized for the benefit of the residents of the homes for the aged such as visits and donations by private welfare organizations and interested people and the recreational activities performed by school children. At present there are twelve homes for the elderly in Thailand.

Social service center for the elderly[4]

In addition to residential care for needy elderly persons, the Department of Public Welfare established the first Social Service Center for the Elderly in August 1979 in the compound of Bangkae Home for the Aged. The eight centers now functioning provide services to both non-residential males and females over 60 years of age who live in nearby areas. They also assist heads of households who face the problems of having elderly as their responsibility. Services provided in these centers are therapeutic and rehabilitative care, recreation, day care, family assistance, counselling services including an opportunity for social and community participation for non-residents in the homes for the aged. In addition to the above, the service centers provide home- visits in the surrounding communities in order to give primary medical treatment to elderly persons. The Elderly Social Service Centers have aided in promoting health conditions for the elderly in general and preventing and rehabilitating infirmity. At present, there are eight social service centers for the elderly. Five out of eight are in-house in a Home for the Aged. The rest are set up for the non-residents who live nearby and also serve as temporary homes for the elderly in case of urgent need.

The cost of operating a home for the aged is rather high and the Government plans to establish more social services centers for the elderly in various provincial areas in the future. The activities of these centers should enable the elderly to remain with and be taken care of by their families, thus lessening the need for additional homes for the elderly.

Non-formal education program

It is well known that education plays a very important role in keeping elderly persons alert and aware of the outside world and helps them to continue to be physically and mentally active. With this in mind, non-formal education projects have been initiated, including the formation of vocational interest groups, education through mass media, village reading centers, audio-visual education, etc., through the Department of Non-formal Education, Ministry of Education. Elderly persons are encouraged to participate in these programs.

However, whether these provisions for educating the aged are appropriate to meet their needs is uncertain. Without any information about the extent of coverage and the requirements of the elderly, it is not possible to evaluate the programs and their effectiveness.

In addition, a health promotion program has been introduced through the Sports Organization of Thailand. The activities under this program include dissemination of knowledge relating to exercise for the elderly, conducting research on physical fitness of the elderly, and organizing tests of their physical fitness. No information on the number and characteristics of the aged who have access to these services is available.

Health and welfare facilities

In view of the problems facing the elderly due to deterioration of health, the Thai Government included a program for prevention and cure of illness and provision of therapy for the elderly as part of the Fourth Five Year Plan (1977-1981). It was recognized that the demand for health care services increases with the growing number of elderly. In 1979 the Ministry of Public Health set up the Advisory Committee for Planning Health Care Programs for Aging. Several programs on health care for the elderly are augmented in general hospitals throughout the country. Many hospitals operate geriatric clinics while the rest are encouraged to provide special care for the elderly. Moreover, the Ministry of Public Health has integrated preventive and curative services for the elderly into the primary health care program.

Apart from these, in 1980 a Special Geriatric Health Service Program was initiated. Its main activities include training of personnel in health care for the elderly, and widening public knowledge in this field through the mass media. One year later, a National Committee on Coordination of Health Care for the Elderly was formed as a planning and coordinating body.

In addition, the Thai Government set up the National Committee for the Elderly in 1982. The committee is chaired by the Minister of Interior and comprises representatives of the public and private sectors whose responsibilities are related to developmental and humanitarian concerns on aging. This committee is entrusted with the responsibilities of policy formulation and planning for all aspects of activities on aging. Seven sub-committees were appointed by the National Committee in 1982.

Information dissemination

The Ministry of Public Health has carried out various programs to disseminate information to the elderly through radio, television and newspapers. The contents of the audio-visual programs focus on physical and mental health of the elderly, disease prevention, etc.

National Aging Day

In compliance with a U. N. Resolution, the Cabinet approved April 13th as National Aging Day. On that day, each province is supposed to arrange activities for the elderly such as paying respect to the aged, physical examinations, providing consultants on laws, exercise, visits to the elderly in the homes for the aged, setting up exhibitions, etc. These are considered one-day service activities.

Government Pension

Government employees who retire from government receive benefits in the form of a lifetime pension or a lump sum payment. The amount of lump sum payment is calculated by multiplying the final month's salary by the number of years in service. The retirement benefits for state enterprise employees are also determined in the same manner except that there is no lifetime pension.

Non-government programs

It is well recognized that active participation of the private sector is an important element in the achievement of overall development. In the field of aging, as in other welfare and development fields, the private sector has played an active role through clubs, foundations and associations. There are quite a number that offer services for the elderly through various kinds of activities. Unfortunately, detailed information is lacking on many of these organizations as they are operated on a voluntary basis.

Foundations for the aged

Various foundations offer care for elderly persons. The most widely known is the Wai Wattana Nivas Foundation which provides housing and services for homeless males over 60. At present there are 450 elderly persons under the responsibility of this foundation; most of them are Chinese and almost half are in poor health. The welfare services of this foundation include housing and food, physical and mental rehabilitation, vocational therapy, etc. Other foundations which provide similar services include the Taranukraw Foundation and St. Louis Foundation. Their main activities focus on humanitarian and developmental aspects of aging. Some private hospitals in Bangkok and the provinces provide free health care for the elderly who are poverty-stricken.

The elderly clubs

With the encouragement and support of the Department of Public Welfare, 90 elderly clubs are operated throughout the country. Each club has its own activities but they are concerned primarily with health, religious and recreational services. There are also associations formed by elderly persons retired from the same organization or the same profession, such as the Retired Interior Officials Association and Retired Militarian Association. These associations carry out activities similar to the elderly club.

In addition to the above organizations, welfare services are found in the field of private business. Some private firms have retirement and pension policies; others do not, and the range and coverage of services vary from one organization to another. The personnel of state enterprises and large-scale private firms are entitled to receive welfare services, while those elderly who were self-employed or worked with small-scale establishments usually have to rely on their families.

Regarding development of support for the elderly, W. S. Chaw in his paper on "The Urban Elderly in Developing East and Southeast Asian Countries" stated there are four stages (Chaw, 1987, p. 99). These are:

Stage 1. Support comes entirely from families and relatives. It is morally obligatory for children to support their elderly parents and failure to do so is regarded as shameful.

Stage 2. Private or charitable institutions for old people are established and accepted as an alternative to family care, especially for the lonely elderly.

Stage 3. Public provision of social services is acknowledged as necessary to supplement family support. The "open care" concept is introduced with community support services provided side by side with institutional care.

Stage 4. Attempts are made to adopt an integrated approach towards the support of the elderly, including a balanced development of cash assistance, in-kind services and a combination of public and family efforts.

The information on government and private services in Thailand indicates that these four stages are applicable to Thailand.

Still, the family has played and continues to play an important function in the care and support for the elderly in Thailand. However, there are some elderly needing care outside of the family system. It seems that charitable institutions for the elderly have begun to increase in number and form. In terms of government services, it is questionable to what extent the government should assist the family in taking care of the elderly and allocate resources for this purpose.

Knowledge of and attitudes toward welfare programs

It is well recognized by the Thais that the elderly should remain in the family and it is the family's responsibility to provide care and support for the aged. Thai people have long been taught to have great filial respect for older people. The traditional family pattern is based on the exercise of moral authority by older people. If the elderly are neglected or abandoned, the blame will fall on their children. However, those elderly who do not have family support require assistance from other sources. For planning purposes, information on knowledge and attitudes of the aged regarding welfare programs is valuable.

The findings in Table 19 indicate that more than half of the elderly do not know about welfare programs, the percentage increasing with age. Only 12 percent know about homes for the aged. Quite a few (27 percent) reported that they are aware of free clothes distribution and food programs. Nearly two-thirds of the urban elderly do not know of any programs in urban areas compared with just over one-third of the rural respondents. The reason for this difference is that most urban elderly are relatively well off as compared to those residing in rural areas and thus may not feel the need for help from the government or other external sources. More women than men report that they are not aware of any programs.

Table 19
Percent Distribution of the Elderly According to Knowledge of Existing Welfare Programs, by Selected Background Characteristics

	Knowledge of welfare programs							
Background characteristic	Don't know	Home for the aged	Free Health care	Free clothes & food	Elderly club	Others	Total	Weighted N
Age								
60-64	52.6	13.9	3.0	30.0	0.3	0.2	100	1,054
65-74	57.3	11.7	3.0	26.9	0.2	0.8	100	1,426
75+	66.4	9.0	2.1	22.3	-	0.2	100	679
Sex								
Male	51.8	14.8	3.9	28.4	0.3	0.9	100	1,285
Female	61.8	9.8	2.1	26.0	0.1	0.5	100	1,874
Urban-rural residence								
Urban	58.9	27.5	3.9	8.4	0.7	0.6	100	538
Rural	37.5	8.6	2.6	30.8	0.1	0.5	100	2,622
Total	57.7	11.8	2.8	27.0	0.2	0.5	100	3,159

More than half of the elderly have never heard of the government homes for the aged (Table 20). A lower percentage of elderly females has heard about the homes than males. A large difference appears between those who live in urban versus rural areas, 75 and 34 percent, respectively. As most of the homes for the aged are located in urban areas while the majority of the elderly people live in rural areas, it is not surprising that 75 percent of urban residents know of them compared with 34 percent of the rural aged.

Table 20
Percent Distribution of the Elderly According to Knowledge of Homes for the Aged, by Selected Background Characteristics

	Ever heard of a home for the aged?			
Background characteristic	Yes	No	Total	Weighted N
Age				
60-64	44.8	55.2	100	1,076
65-74	40.9	59.1	100	1,459
75+	36.5	63.5	100	692
Sex				
Male	47.7	52.3	100	1,323
Female	36.8	63.2	100	1,904
Urban-rural residence				
Urban	75.4	24.6	100	556
Rural	34.1	65.9	100	2,671
Total	41.2	58.8	100	3,227

Table 21
Percent Distribution of the Elderly According to Whether had Ever Thought of Living in a Home for the Aged, by Selected Background Characteristics

Background characteristic	Yes	No	Don't know	Total	Weighted N
Age					
60-64	9.1	35.5	55.4	100	1,072
65-74	8.5	32.0	59.5	100	1,451
75+	7.5	28.9	63.6	100	691
Sex					
Male	9.8	37.6	52.6	100	1,315
Female	7.6	29.0	63.4	100	1,899
Urban-rural residence					
Urban	15.9	59.5	24.6	100	566
Rural	6.9	26.9	66.2	100	2,657
Total	8.5	32.5	59.0	100	3,214

When it comes to the question of whether they have ever thought of living in a home for the elderly (Table 21), only 9 percent reported doing so, while 33 percent had never done so. The rest, 59 percent, are those who don't know or never heard of the homes for the aged. The low percentage of those who have considered living in a home for the aged reflects the widespread belief that being in a home for the aged has negative consequences for their status. The family that places the elderly in a home for the aged is seen as showing no filial relationship between children and parents. The programs for the aged are considered to be charity rather than welfare, so the elderly persons who live in a home for the aged tend to feel shame and not many Thais want to live there. Strategies to increase acceptance of the welfare concept and to change the nature of institutional care are drawing greater attention from the Thai people. It may be noted that the percentage of the urban elderly who ever thought of living in a home for the aged is more than double that of rural residents, indicating more knowledge about the homes and awareness of their services.

Table 22
Percent Distribution of the Elderly According to Knowledge of any Associations or Groups Which Have Some Activities or Recreation for the Elderly, by Selected Background Characteristics

Background characteristic	Yes	No	Don't understand	Total	Weighted N
Age					
60-64	26.4	73.5	0.1	100	1,076
65-74	22.2	77.6	0.2	100	1,457
75+	17.9	82.1	-	100	691
Sex					
Male	27.2	72.5	0.3	100	1,322
Female	19.5	80.5	-	100	1,901
Urban-rural residence					
Urban	41.0	59.0	-	100	555
Rural	18.9	81.0	0.1	100	2,668
Total	22.7	77.2	0.1	100	3,223

Associations or groups which offer some activities or recreation for the aged are also of interest. Table 22 shows that less than one-quarter have ever heard of such associations or groups and the percentage increases with advanced age. The percentage of elderly persons who have ever heard of such groups is higher among males than among females, and it is much higher among urban residents. Among those who have heard of associations or groups, (Table 23) less than 10 percent reported they are members. There is no difference between urban and rural elderly in membership status.

Table 23
Percent Distribution of the Elderly Who Have Heard of an Association that Provides Activity for the Elderly According to Membership in an Association, by Selected Background Characteristics

	Membership			
Background characteristic	Yes	No	Total	Weighted N
Age				
60-64	9.8	90.2	100	282
65-74	8.4	91.6	100	321
75+	9.7	90.3	100	125
Sex				
Male	10.7	89.3	100	362
Female	7.7	92.3	100	366
Urban-rural residence				
Urban	9.4	90.6	100	226
Rural	9.1	90.6	100	502
Total	9.2	90.5	100	728

Elderly clubs were set up with the purpose of providing opportunities for the elderly to participate in social, economic, health promotion activities, hobbies, etc. As shown in Table 24, most of the elderly report knowing of no elderly club in their vicinity. Only three percent know that an elderly club exists in their community or village. An unexpected finding is the higher percentage of urban elderly who do not know about elderly clubs, perhaps because the urban population has more opportunity to participate in many kinds of social activites.

Table 24
Percent Distribution of the Elderly According to Knowledge of an Elderly Club in the Community or Village, by Urban-Rural Residence

	Have and elderly club				
Residence	Yes	No	Don't know	Total	Weighted N
Urban	7.2	77.0	15.8	100	555
Rural	2.3	90.5	7.2	100	2,668
Total	3.2	88.2	8.7	100	3

Asked about joining a group with the objective of promoting the living conditions of the aged, only one-third of the elderly indicated an interest. Of those who said they would join, nearly one-third prefer an informal type of organization while only 15 percent want a foundation (Table 25). The concept of formal organization appears to be more familiar to urban elderly as 33 percent of the urban elderly report that a foundation is the form that they need while the rural prefer informal group gatherings. It should be noted that 9 percent of the respondents do not understand the question or the idea of organizational types.

Table 25
Percent Distribution of the Elderly Who Want to be Member of a Group Promoting the Living conditions of the Aged, by type of Organization, Preferences and Selected Background Characteristics

	Type of organization										
Background characteristic	Foundation	Assciation	Co-opertive	Informal	Club	Don't know	No Preference	Don't understand	Don't know no answer	Total	Weighted N
Age											
60-64	16.0	5.9	8.8	23.0	5.9	0.7	10.3	7.0	22.3	100	799
65-74	15.7	3.7	7.6	21.6	3.2	0.6	11.8	10.1	25.7	100	997
75+	11.3	3.6	6.6	20.7	2.5	0.5	7.8	9.8	37.2	100	350
Sex											
Male	18.0	5.9	10.8	21.7	5.8	1.0	10.4	7.3	19.3	100	984
Female	12.6	3.3	5.4	22.2	2.6	2.6	10.8	10.2	32.3	100	1,162
Urban-rural residence											
Urban	32.6	7.3	5.0	14.1	7.4	1.3	8.1	6.3	31.2	100	303
Rural	12.2	4.0	8.4	23.3	3.6	0.5	11.0	9.3	27.7	100	1,843
Total	15.1	4.5	7.9	22.0	4.1	0.6	10.6	8.9	26.3	100	2,146

Half of the elderly who want to participate in an organization to promote living conditions want to make no contribution themselves (Table 26). There are only slight differences in this regard between males and females and between urban and rural residents. One-third of the elderly prefer to make a partial contribution, but less than one-percent suggest that the group should be self-supporting.

Table 26
Percent Distribution of the Elderly Who Want to be Members of a Group Promoting the Living Conditions of the Aged, by extent of Members' Contribution and Selected Background characteristics

Background characteristic	Extent of Menbers' Contribution								
	None	Partial	Total	Depends	No preference	Don't understand	Don't Know no answer	Total	Weighted N
Age									
60-64	50.8	33.3	0.5	1.1	3.5	1.6	9.1	100	799
65-74	55.5	27.6	1.0	0.5	3.1	2.7	9.7	100	997
75+	49.5	24.2	1.4	0.5	3.8	2.9	17.7	100	350
Sex									
Male	50.3	36.1	1.2	0.6	2.0	1.8	7.9	100	984
Female	54.7	23.3	0.5	0.8	4.6	2.7	13.3	100	1,162
Urban-rural residence									
Urban	50.0	35.3	1.4	1.3	1.8	1.1	9.3	100	303
Rural	53.2	28.2	0.8	0.6	3.6	2.5	11.1	100	1,843
Total	52.7	29.2	0.9	0.7	3.4	2.3	10.8	100	2,146

Turning to their attitudes on the most important welfare benefit the government should give to the elderly (Table 27), financial assistance is most frequently mentioned. Next is free health care. This finding is understandable since persons 60 years and over generally have lower economic status than the younger generation, and are more vulnerable to disease. Thus, they need both financial and health welfare, female and rural elderly more than male and urban elderly. Nine percent of the elderly mentioned housing, with a higher percentage in urban than rural areas.

Table 27
Percent Distribution of the Elderly According to the Most Important Type of Welfare the Government Should Provide for the Elderly, by Selected Background Characterestics

	Type of welfare										
Background characteristic	None	Housing	Monthly allowance	Free health care	Find Job	Take care of funeral	Food	General support	Other	Total	Weighted N
Age											
60-64	1.5	11.3	34.9	34.1	1.9	1.1	7.3	5.5	2.4	100	956
65-74	1.9	8.9	28.2	33.8	1.3	1.0	7.6	5.2	2.1	100	1,267
75+	2.8	6.3	39.3	29.9	1.2	1.3	10.0	7.2	2.1	100	570
Sex											
Male	1.8	10.2	31.1	38.1	1.8	1.2	8.5	4.3	3.1	100	1,192
Female	2.0	8.5	42.0	29.4	1.2	1.0	7.6	6.8	1.6	100	1,597
Urban-rural residence											
Urban	3.1	23.3	29.6	30.3	2.1	0.4	5.4	4.6	1.2	100	489
Rural	1.7	6.2	38.9	33.7	1.3	1.3	8.5	5.9	2.4	100	2,304
Total	1.9	9.2	37.3	33.1	1.5	1.1	8.0	5.7	2.2	100	2,793

Summary

In summary, programs for the elderly in Thailand are limited and not widely distributed in rural areas, especially programs concerned with residence and living arrangements, recreational and social programs. No income maintenance program exists. Most of the elderly in Thailand live either in their own homes or those of their children; the poor elderly without anyone to care for them suffer the most. Because of the limitation of sources of services and the distance from existing programs, the poor and destitute elderly may have severe problems, particularly those in poor families where women and the young have to join the labour force. Many elderly are thus left alone at home. The low income not only erodes family ties but also limits the opportunity of the elderly to get government services, as they have to concentrate on mere survival. It is now necessary to consider income security for the elderly. Family support involves the development by government of incentive measures to stimulate family care of the elderly. In addition, the government tends to limit rather than expand the number of homes for the aged due to the high cost of operation and, instead, to set up more programs for the non-institutional elderly.

However, no matter what programs the government or private sector offer to the elderly, more information about them should be disseminated to achieve better understanding, not only in terms of awareness and knowledge of the programs, but also to clarify their role as promoting the country's social welfare and betterment.

Policy and Program Issues

Today, most of the Thai elderly live with their children. Policy issues concerned with maintaining and supporting this practice include the development of incentive measures such as tax deduction programs or increased monthly allowances for those responsible for their aged parents.

THE IMPACT OF LIVING ARRANGEMENTS OF THE ELDERLY ON GOVERNMENT PROGRAMS IN THAILAND

As Thailand moves from being an agricultural to a newly industrialized country, the family structure is changing from the extended family to the nuclear family, accommodating only the spouses and their children. Consequently, the elderly are left increasingly to stay by themselves. In the future, the necessity of having a social security system in Thailand is evident. The effectiveness of the family planning program assures that the future Thai elderly will have fewer children to rely upon. Especially in rural areas, the view is still prevalent today that children are the most reliable source of care and support in old age.

Old age security schemes that are appropriate to Thailand should be carefully studied. The delay in setting up a social security program in this country is due partly to the fact that most Thais do not yet understand the concept of a social security system. From the pretest of the SECAPT questionnaire, it was found that most of the elderly respondents did not understand a question on the social security system nor, could they give meaningful answers because they were unsure of its purpose.

Finally, policy and programs could be designed to provide for older persons in a wide variety of ways, including political affairs and community affairs. The government should provide older persons with the opportunity to remain active participants in the life of the community.

Perhaps the government, as it is called upon increasingly to meet social welfare needs of the aged, should focus first upon the difficulties faced by the very old, especially those living in rural areas who have no living children or other relatives to care for them, and the unmarried elderly. Of these, women, whether single or widowed, appear the most vulnerable and in need of support.

Thailand is undergoing rapid industrialization but, for some time to come, the majority of its population will depend upon agriculture and agro-industries for a livelihood. The combination of industrialization and urbanization can be expected to lead to incorporating some form of social security into the social welfare system. The governments' efforts in providing social security should be supported by both the public and private sectors through maintaining traditional concepts such as filial piety, respect for the aged and the primary role of the family, to the extent possible, in caring for the elderly. The objective is to provide older persons with an opportunity to remain active participants in the life of the family and the community.

References

Andrews, G., et al. (1986). *Aging in the Western Pacific*. Four Country Study, WHO, Western Pacific, Manila, Philippines.

Cantor, M.H. (1987). Pattern of aging and social supports in the United States. In *Aging China: Family, economics and government policies in transition*, ed. by James H. Schulty & Deborah Davis Freedman. The Gerontological Society of America.

Chaw, W. S. (1987). The urban elderly in developing East and Southeast Asian Countries. In *Aging China: Family, economics and government policies in transition*, ed. by James H. Schultz & Deborah Davis Freedman. The Gerontological Society of America.

Hugo, G. (1985). Population Aging: Some demographic issues in developing countries. Background paper prepared for Version VI of the Program for Developing Country Participants, International Congress of Gerontology, New York, July 12-17th.

Kendig, H.L. (1987). Roles of the aged, families and communities in the context of an aging society. *Population Aging: Review of emerging issues*. United Nations.

Kendig, H.L. & McCallum, J. (1986). *Greying Australia*. Australian Government Publishing.

Kiranandana, S. (1985). *Implications of demographic change for old aged security in Thailand*, 1987-2021. Population Policy Background Paper, TDRI.

Plange, N.K. (1987). Within the family and the community: Family and community relations of the elderly in Fiji. Paper presented at Seminar on Research on Aging in Asia and the Pacific, August 31-September 4, 1987. Singapore.

Rosenmayer, L. (1972). The Elderly in Austrian Society. *In Aging and Modernization,* ed. by Cowgill and Holmes, New York.

Treas, J. (1975). Aging and the family. In *Aging: Scientific Perspectives and Social Issues.* California: Brooks/Cole Publishing Company, .

United Nations (1987). *The Family* No. 4. Strengthening the Family: Guidelines for the Design of Relevant Programmes.

Viscusi, W.K. (1981). An assessment of aid to the elderly: Incentive effects and the elderly's role in society: In *Aging Stability and Change in the Family*. ed. by James G. March and others, N.Y. : Academic Press,

Endnotes

[1] Source: The Working Group on Population Projects of the Sub-Committee on Population Policy and Planning (1986), Population Projections for Thailand 1980-2015, pp. 16-19.

[2] For details of the sampling and interviewing techniques employed in this survey, see: Napaporn Chayovan, Malinee Wongsith and Chanpen Saengtienchai, *Report on Socio-Economic Consequences of the Aging of the Population in Thailand.*

[3] Unpublished paper from the Department of Public Welfare, Ministry of Interior.

[4] Unpublished paper fro the Department of Public Welfare, Ministry of Interior.

[5] The Sub-committees are: Health Care, Social Welfare, Culture and Education, Research and Long-term Planning, Public Relations, Foreign Relations and Fund Raising.

CHAPTER 17

OPERATION AND DEVELOPMENT OF PROGRAMS FOR COMMUNITY CARE FOR THE LOW INCOME ELDERLY IN SEOUL

Ki-Dong Cho

I would like to give you an idea of the situation the poor aged face in Korea. I also want to discuss the Home Help Service. The first thing to emphasize is that our Home Help service is an entirely new program in Korea, especially since we operate it on a purely volunteer basis. We believe, however, that in starting this service we are following the lead of early care for the elderly in many of the more developed countries.

It is very important to give a little bit more background to our situation. Historically, in Korea we have had the extended family system. As in many other Asian countries, it is not uncommon to find three or even four generations living under one roof. This has its base in two main factors.

Firstly, the traditional agricultural society was dominant only 40 or 50 years ago. *Secondly*, and even more importantly, are the Confucian ideas which have dominated Korean thinking since the Fifteenth century. In this philosophy the elderly are to be revered and could thus expect to be cared for in the family. In the absence of an immediate family, responsibility would be taken by more distant relatives, neighbors or the community in general. However, Korea's rapid economic progress in the last 25 years has disturbed this system. Urbanization and industrialization combined with increased life expectancy and modern medicine has meant that Korea is moving towards the nuclear family as the basic unit.

Table 1
Population and Percent of Elderly

	Year						
	1960	1970	1980	1985	1990	1995	2000
Total Population	24,989	31,435	36,124	41,056	43,601	45,962	48,017
Population over 65	825	1039	1372	1741	2025	2397	2972
% of Total Population 65+	3.3	3.3	3.8	4.2	4.7	5.2	6.2

Source: Ministry of Health and Social Affairs

The first table shows the growth of the South Korean population over the last three decades and makes projections for the next decade. You will see we have an increasing number of elderly people in our communities. Unfortunately, though, we do not yet have a system to replace the old Confucian ideas. In rural areas the young people move away and the elderly are left alone, and in the cities the high rise flats can often not accommodate elderly parents or relatives.

The second table shows who our elderly live with. Overall, you see that almost 80% live with one of their children. The largest proportion live with their eldest son, who sees it as his duty to them -- his filial piety. That 80% do live with their children is high compared to Western societies. For example less than 10% in the United States or Britain live with their children. However, it is clear that Korean society is changing so fast that we can no longer assume that families will take responsibility for elderly relatives.

Table 2
Who Our Elderly Live With

	National	Urban	Province	Rural
Alone	20.5	15.3	18.4	23.3
With eldest son	39.6	35.0	40.6	41.0
With another child	12.5	11.7	10.6	13.7
With unmarried child	23.6	31.3	25.1	19.4
With daughter and son-in-law	2.7	5.5	3.9	1.3
Other	1.1	1.2	1.4	1.3
Total %	100.0	100.0	100.0	100.0

At HelpAge Korea, we believe that the plight of the poor or lonely elderly will only get worse and so we initiated the Home Help Service based upon volunteers from the community.

We began by trying to identify the neediest among the 900 old people already being sponsored by our organization. In January, 1987 we constructed a questionnaire and began visiting 200 of these people.

The following results emerged: The average age was 71.8 and almost 79.5% of these neediest cases were women. Only 10% were couples. So we know that elderly women formed the bulk of these needy people. In terms of living conditions, 52.5% rented their own places; 23% lived with a daughter or other close relative, and 24.5% lived with friends or neighbors. These figures sharply contrast with the national figures I mentioned earlier. Of the 200, more than half felt that there was nobody who really cared what happened to them.

As I said earlier, a Home Help Service is a very new idea in Korea and only about 30% of the elderly we talked to thought they wanted it. This high degree of independence is further reflected in that only 1% would have liked to be able to go into an old people's home. Most wanted to stay where they were because, in these very poor areas of the city, the great concentrations of people in a very small area fosters a neighborhood spirit that inclines the elderly to feel there might be someone to look out for them, in case of illness or accident.

We finished the survey in April, 1987 and had by then identified the people we would help first. The next step was to form the advisory committee. We were able to get the participation of two professors of social work and two government officials. We then sat down and worked out the initial plan.

Table 3
Work Plan

	87.1	2	3	4	5	6	7	8	9	10	11	12	88.1	2	3	4	5	6
Collect information	---	---	---															
Survey of elderly	---	---	---	---														
Advisory committee					--													
Recruiting volunteers		---	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Training					--					--				--				
Case study meetings		---	---	---	---	---	---	---	---	---	---	---	---	---	---	---		
Evaluations					--						--				--			

The next step was the one which I had thought would be the most difficult -- the recruitment of volunteer Home Helpers. However, we had the unexpected support of the mass media. This free publicity meant that although we had aimed to have 80 volunteers in the first 12 months, we now have 132, of whom only six came to us through means other than hearing about our project in the media. Over the past 14 months we have been on television 6 times, radio 21 times and in the daily papers and magazines 26 times.

Our first training session took place in May 1987 and we have had three more since then. Each session lasts about six hours and at the end we give the volunteer a photo and a map to the home of their old person. The volunteers in the first two sessions were placed where we felt the neediest people to be, but we have tried to match the more recent volunteers with old people in their own areas.

Table 4
Motivation to be a Home Helper

	Age					
	20's	30's	40's	50's	Total	% of Total
Religious conviction	12	6	8	4	30	22.7
Thinking of own parents	3	1	0	1	5	3.8
Want to help others	16	11	4	2	33	25.0
Education	0	1	2	0	3	2.3
Promote a meaningful life	6	2	4	1	13	9.9
Mass Media	7	7	1	1	16	12.1
Other	18	6	6	2	32	24.2
Total	62	34	25	11	132	100.0
% of Total	47.0	28.0	18.9	8.3	100	

Table 4 shows a breakdown of our volunteers. Their average age is 36, and of the 132, only 23 are men. 47% are in their 20's, 25.8% in their 30's, 18.9% in their 40's and 8.3% over 50. Their reasons for joining our Home Help Service vary, with 22.7% doing it because of their religious convictions, 25% because they want to help others and 12.1% because of the media influence. In terms of religious background, they are 60.6% Protestant, 15.9% Catholic, 2.3% Buddhist and 21.2% of no organized religion. In terms of education they break down to 29.5% university graduates, 54.5% high school graduates, 9.9% middle school graduates, and 6.1% with no formal education at all.

The helpers are generally matched on a 1:1 basis and expected to make one visit a week of about 3 hours. One lady though has 7 old people she visits -- taking up 2 full days a week.

The type of help they offer varies, of course, depending on the individual's health and circumstances. We only ask that they do the most needed service. After each visit they are supposed to write a short report and around 40% do that. The typical reactions we get in these reports are that the helper did not realize there was this kind of suffering; that they are glad to be able to help; that they want to do their best and so on. In general, they are very sentimental reactions.

You will see from table 5 that conversation and a friendly talk is the single biggest service these helpers offer, followed by massage and taking the old people out for a walk. Most of these elderly people remain fiercely independent and so the links tend to be very emotional.

Table 5
Types of Service

	%
Friendly talk	45.5
Taking on a walk	11.5
Massage	11.4
Cleaning	6.4
Laundry	4.4
Collecting food rations	4.5
Cooking	4.5
Taking to official offices	6.9
Total	100.0

This is typical of traditional Korean society and the relationships which develop are very much mother/daughter or grandmother/granddaughter. Even if the help extends beyond that, the relatively short time allocated and lack of professional expertise can limit its effectiveness in the most severe cases.

Every Home Helper is assigned to one of three case discussion groups which meet once a month under the guidance of our volunteer social work professors. These discussion meetings were not in our original plan, but we now see they are vital for the support of the helper and success of the project. In the meetings each person talks about his or her case and problems are discussed. The most significant problems to have arisen are, for example:

1. The emotional relationship between the helper and the old person can cause major problems if the tie is broken;

2. Most of our volunteers take gifts when they visit -- they are unable to go empty-handed. We had not intended this and are concerned that the old people should not become reliant on these gifts, and that they should not be a burden for the helper; and

3. The weekly visits are inadequate in the case of an emergency.

We have found that the meetings are invaluable in identifying problems such as those mentioned and in continuing the education of our home helpers.

So, that is where we are with our pilot Home Help Service project in Korea. We have found that the recruitment of volunteers is easier than expected, and that they are filling a very necessary gap in the lives of our poor or lonely elderly. We are aware, though, of the need to improve the quality of our helpers. We must emphasize the importance of the continuity of service and minimize the drop out rate. A rather bigger issue is whether we need to expand our service to include professional care givers. This is in the future and will come when the Home Help Service is part of a total family welfare package. Part of our success is that we have generated increased government awareness of the plight of the elderly. Although we have had a good response from the community, and we are happy to have raised awareness of the problem, we know that in the future a total reliance on volunteers is not feasible. Instead, we would hope our volunteers could work as an adjunct to a government sponsored program. We must look at and attack all the problems of these disadvantaged old people. We need resources for far more intensive training; we need facilities to be able to transport the needy to a hospital -- this Home Helper Service is only the beginning.

KOREA DATA ADDENDUM

INDICATORS OF HEALTH STATUS OF OLDER PEOPLE IN KOREA: IMPLICATIONS FOR LONG TERM CARE POLICY AND PLANNING

James Y. Koh

Table 1
Population Statistics for the Republic of Korea, 1955-2020

Year	Total N (1000)	65+ N (1000)	0-14 %	15-64 %	65+ %	Aged Dependency Ratio
1955	21,502	714	41.2	55.4	3.3	6.0
1960	24,989	935	42.9	53.8	3.3	6.1
1966	29,160	961	43.5	53.2	3.3	6.2
1970	31,435	1,039	42.1	54.6	3.3	6.0
1975	34,679	1,229	38.1	58.4	3.5	6.0
1980	38,124	1,449	34.0	62.2	3.8	6.1
1985	41,056	1,760	30.6	65.2	4.2	6.2
1990	43,601	2,175	27.2	68.1	4.7	7.0
1995	45,962	2,657	25.2	69.6	5.2	7.5
2000	48,017	3,356	23.1	70.7	6.2	8.8
2020	52,473	5,772	17.6	71.4	11.0	15.4

Source: National Bureau of Statistics, Economic Planning Board, Republic of Korea, Population and Housing Census Report; 1966, 1970, 1975, 1980, 1985; Population Projection based on 1985 Census Report, National Bureau of Statistics, 1986.

Table 2
Percent of Population 65 and Over, Selected Countries, 1980

1. **Young Populations (less than 4%) :**
   2% -- Afghanistan, Ivory Coast
   3% -- India, Pakistan, Thailand

2. **Youthful Populations (4% - 6%):**
   4% -- Korea, Malaysia, Brazil, Egypt
   5% -- Taiwan, Ethiopia
   6% -- China, Chile

3. **Mature Aging Populations (7% - 9%):**
   7% -- Hong Kong
   8% -- Cuba
   9% -- Japan, Canada

4. **Aged Populations (10% and Over):**
   10% -- Australia, Poland
   11% -- United States, Spain
   12% -- Netherlands, Bulgaria
   13% -- France, Gree Kingdom
   14% -- W. Germany, Swiss
   15% -- Denmark, England
   17% -- Sweden

Source: Population Reference Bureau, 1983 World Population Data Sheet,
Washington D.C.: Population Reference Bureau, April 1983.

Table 3
Changing Age Composition of the Older People in the Republic of Korea, 65 and Over, 1955-1985

Year	65+	65-69	70-74	75-79	80+
1955	707,806	356,658	191,111	106,045	53,992
1966	1,039,378	437,384	267,288	172,669	84,977
1975	1,206,599	542,827	325,213	175,416	113,803
1985	1,749,549	722,817	501,254	312,090	213,388
		Percentage (%)			
1955	100.0	50.4	27.0	15.0	7.6
1966	100.0	45.5	27.8	17.9	8.8
1975	100.0	45.0	27.0	16.9	11.1
1985	100.0	41.3	28.7	17.8	12.2

Source: U.N. Demographic Yearbook 1963, 1973; National Bureau of Statistics, Economic Planning Board, Republic of Korea, Population and Housing Census Reports, 1975, 1985.

Table 4
Life Expectancy at Birth and at age 60 by Sex, 1905-2015

	At birth		At 60	
Year	Male	Female	Male	Female
1905-1910	22.6	24.4	10.5	11.6
1945-1950	45.6	50.7	12.2	14.9
1960-1965	54.9	61.0	12.2	16.7
1970-1975	60.0	67.0	12.4	17.3
1980-1985	65.0	71.0	--	--
1990-1995	68.2	75.0	14.1	20.8
2000-2005	69.3	76.2	--	--
2010-2015	73.0	81.1	--	--

Source: (1) Jung Keun Kim, Health Status and Services for the Korean Aged, *Journal of Korean Gerontological Society*, Vol. 4, p. 62-63; National Bureau of Statistics, Population Projections, March 1986.

Table 5
Crude Rates of Live Birth and Death in Korea, 1960-1984

Year	Birth Rate	Death Rate
1910	39.0	34.0
1940	42.0	23.0
1951	40.0	33.0
1960	42.0	13.0
1965	33.9	10.0
1970	29.5	8.5
1975	23.9	6.5
1980	23.4	6.2
1984	23.0	6.2

Source: Andrew Mason, Demographic Prospects in the Republic of Korea: Population, Households, and Education to the Year 2000. East-West Population Institute, Working Papers, No. 43. Honolulu, Hawaii, September 1986; Quarterly Bulletin of Statistics for Asia and the Pacific, Vol. 15, No. 4, Economic and Social Commission for Asia & Pacific, United Nations, December 1985.

Table 6
Primary Causes of Death in Korea, 1966-1985

1966	1985
1. Influenza/pneumonia	1. Cerebrovascular disease
2. Tuberculosis	2. Malignant neoplasms (all cancers)
3. Cerebrovascular diseases	3. Hypertensive diseases
4. Infectious/parasitic diseases	4. Other heart diseases
5. Malignant Neoplasms (all cancers)	5. Respiratory diseases
6. All accidents	6. All accidents
7. Respiratory diseases	7. Liver diseases
8. Lung disease	8. Diseases of the digestive system
9. Heart diseases	9. Tuberculosis
10. Diseases of the digestive system	10. Influenza/pneumonia

Source: National Bureau of Statistics, Economic Planning Board, *Annual Report on the Primary Causes of Death, 1985.*

Table 7
Major Health Problems of the Korean Aged by Age and Sex

	Total	60+		80+	
Health	60+	Male	Female	Male	Female
Problem	%	%	%	%	%
Chewing	60	59	61	63	77
Dental prosthesis	38	38	39	50	20
Sight problems	33	31	34	42	45
Foot problems	19	16	21	29	23
Hearing Problems	17	17	17	38	41
Walking	15	15	14	29	30
Cataract	10	11	9	17	16

Source: Jong Huh & Seon Ja Rhee, "1984 Survey on Health Status of the Korean Aged," *Journal of Korea Gerontological Society*, No. 5. Seoul, Korea: Korean Gerontological Society, 1985.

Table 8
Percentage of People Age 60 and Over Who are Unable to perform ADLs, by Age and Sex

	Total	60+		80+	
	60+	Male	Female	Male	Female
Type of Activity	%	%	%	%	%
Eating	0	0	0	0	0
Dressing	0	0	0	0	0
Walking	1	1	1	4	2
Transferring	2	2	2	4	5
Bathing	1	2	1	0	0
Grooming	0	0	1	0	0
Toileting	22	19	24	38	32
Go Shopping	8	7	8	13	23
Handle money	5	3	7	8	20
Walking 300 m	7	6	8	17	11
ADLs - No difficulty	71	73	69	46	48
ADLs - 1 difficulty	21	20	21	38	23
ADLs - 2 or more difficulties	8	7	10	16	29

Source: Jong Huh & Seon Ja Rhee, "1984 Survey on Health Status of the Korean Aged." *Journal of Korea Gerontological Society*, No. 5. Seoul, Korea: Korea Gerontological Society, 1985.

Table 9
Use of Health Professionals, Medication, and Needed Services by Age and Sex

Use of Health Services	Total 60+	60+		80+	
	%	Male %	Female %	Male %	Female %
Health Professionals:					
Medical Doctor	20	21	17	17	9
Nurses	1	1	1	0	2
Pharmacist	27	25	29	8	27
Medication:					
Prescribed	24	26	21	22	17
Over the counter	42	38	45	30	40
Traditional	29	29	29	30	21
Needed Services:					
Medical care	48	45	51	26	38
Health aids*	17	15	19	17	33

Source: Jong Huh & Seon Ja Rhee, "1984 Survey on Health Status of the Korean Aged." *Journal of Korean Gerontological Society*, No.5. Seoul, Korea: Korea Gerontological Society, 1985.

* Includes Eye glasses, hearing aids, dentures, etc.

Table 10
Living Arrangements of the Korean Aged 65 and Over, 1986

Living Arrangement	All Country %	Urban %	Rural %
Living with Spouse only or living alone	20.5	15.3	23.3
Living with Adult Children/ Grand Children	78.4	83.5	75.4
Living with other relatives	1.1	1.2	1.3

Source: Jong Kwon Im, *Social Security Research*, Vol. 2 (1986): 164.

Table 11
Marital Status of 65 & Over by Sex, 1970-85

		Year			
Sex	Marital Status	1970 %	1975 %	1980 %	1985 %
Male:					
	Married	73.5	68.9	79.9	82.3
	Widowed	26.0	22.0	19.7	17.3
	Divorced	0.3	0.2	0.2	0.2
	Single	0.1	0.1	0.2	0.2
Female:					
	Married	21.7	24.3	24.3	27.5
	Widowed	78.0	75.3	24.3	72.2
	Divorced	2.5	0.2	0.2	0.2
	Single	0.1	0.1	0.1	0.1

Source: National Bureau of Statistics, Economic Planning Board, Republic of Korea, *Population and Housing Census Report, 1970, 1975, 1980, 1985.*

Table 12
Old Age Welfare Institutions and Inmates in Korea, 1955-1988

Year	No. of Institutions	Inmates
1955	22	439
1965	42	2,567
1975	45	2,444
1980	48	3,136
1988	76	5,648

Source: Ministry of Health and Social Affairs, "Current Status of Old Age Institutions," 1988.

CHAPTER 18

THE KOREAN-AMERICAN URBAN ELDERLY

Jung-Sup Kim
and
Paul K. H. Kim

Introduction and Purpose

One of the many discoveries of Americans in the last quarter of this century is of an untapped human resource that has been in existence on the other side of the globe, the Continent of Asia, the Far East, and, particularly, the Southeast. Since the enactment and implementation of the U.S. Immigration Law of 1965, the door to America has been open to Asians. Therefore, they came with their scientific knowledge, experience, wisdom, and professional skills that America needs. They bring with them their respective cultures and traditions, consequently enriching the quality of the pluralistic democracy that has been cherished by Americans. Every year since the mid-60's, Asian immigrants have outnumbered Europeans, and the largest fraction of them has been those from the Philippines, South Korea, and, more recently, from Southeast Asia as a consequence of the fall of Vietnam in 1975.

The number of Korean-Americans today is estimated to be about 800,000, about 10% of whom are age 60 and over. While slightly more than one-half of recent immigrants find their new homes in the Pacific coastal states, two additional major areas of concentration can be found in the Mid-West (primarily the Chicago area) and in the Atlantic coastal states; i.e., New York, and the District of Columbia area, including its Maryland and Virginia suburbs. It is estimated that about 200,000 Korean-Americans enjoy living in the Greater

New York area, with about 20,000 of them being 60 years old and older. Moreover, with more than one-half of pending immigrants indicating their plan to live in the New York area, the number of Korean-Americans, including their elderly individuals, is inevitably expected to increase.

The objectives of this chapter are to delineate the social and demographic situations of Korean-American elderly living in the New York area; to identify some problems in living in their adopted country; and to discuss relevant public policies and social programs that are designed to enhance the quality of life of elderly newcomers to the States. Thus, this research is a longitudinal study for trend analysis, which is based on secondary data collected during the last five year period.

Method of the Study

This chapter is based on three exploratory studies completed in the 1980's. Brief descriptions of each research project are as follows:

Table 1
Three Studies: Year, Sampling Method,
Size of Sample, and Age Limit

Researcher	Year	Sampling Methods	Size of Sample	Age Limit
James Y. Koh	1983	Non-Probability	151	60 +
Jung-Sup Kim	1987	Non-Probability	538	60 +
Jung-Sup Kim	1988	Non-Probability	69	61 +

Sample participants were exclusively residents of the City of New York and its surrounding communities, and were located through ethnic, social, cultural, and religious organizations in the area, as well as through local ethnic newspapers. Koh (1983) used the interview method of data collection with a structured questionnaire, while Kim

(1987; 1988) used a structured questionnaire, either mailed or delivered, to potential respondents, who were instructed to return the completed questionnaire to the designated office of research. Since 1983, the minimum ages of sample participants for the1987 and 1983 studies were 55 and 20, respectively. It is imperative to develop sub-sample groups from both studies in order to make any rational comparisons and empirical generalizations. Thus, sub-sample groups of 538 (of 626) and 69 (of 436) were established from the respective studies. The age limit of sample participants for the 1983 and 1987 studies was 60 +, while the 1988 study included 60 +.

Objectives of the 1983 and the 1987 studies were about the same, in that both were designed to study social and demographic characteristics of Korean-American elderly. Consequently, their respective structured questionnaires included similar items. On the other hand, since Kim's 1988 study was to identify the priority of social programs, as perceived by Korean-Americans in the New York area, items in the structured research instrument do not necessarily include questions used in the two previous studies. Moreover, priority responses in the third study were construed to be "problem areas" as perceived by respondents. Therefore, among the many research variables included in the three studies, only those that can be used for a trend analysis have been selected; i.e., age, sex, marital status, religious affiliation, the number of years lived in U.S., and socioeconomic status. Problems and prospects involving transportation and employment needs, and family situations, are incomplete for any comparison and, thus, they are excluded in the final analysis.

It is worthwhile to look into the quality of life data, as well as the elders' choice of their confidants, as depicted in the 1988 study. Nineteen attitudinal quality of life items were analyzed and their degree of significance tested. Furthermore, the relationship of Korean-American elderly with their confidants was examined. Nevertheless, in view of a small sub-sample (69), it should be noted that the sampling error of the 1988 study is + or - 12 percent.

Results and Discussion

The median age of Korean-American elderly has decreased about 10% during the five year period, from age 73 to 66. This fact is indicative of an increased number of elderly who have attained the age of 60 recently. In fact, middle-aged immigrants who came to America in the late 1960's and 70's are now in their early 60's. Many elderly parents come to the States following their children who have established their naturalized U.S. citizenship. Many elderly appear to be recent immigrants, having lived in the U.S. about 5 to 8 years only. Consequently, the segment of older persons among Korean-Americans will be the fastest growing population, as has been seen in the U.S. population in general. Moreover, female elderly outnumber their male counterparts by 2 to 1, which is a significant change from that of 1983, when the ratio was about the same, one to one. As they grow older, the number of married elderly has been reduced by 33% since 1983. This phenomenon indicates that, as in Korea where slightly more than three of four elderly have lost their spouse (United Nations, 1984), the number of Korean-American elderly who are widowed and/or unmarried single individuals is ever increasing.

Although Buddhist temples are burgeoning in America, a majority number of Korean-American elderly identify their religious affiliation with Christianity, either Protestant or Catholic. Korean ethnic churches are highly visible wherever Korean-Americans live and serve congregations in their spiritual, as well as social and physical needs.

Contrary to public opinion that classifies Asian-Americans as a so-called "model minority," who are not necessarily an economic liability to American society, economic conditions of the Korean-American elderly are characterized as poor. About one in two (47%) older persons received SSI in 1983 and 1987. Since the 1983 study, the number of elderly persons who live below the poverty level has substantially increased about six-fold -- 12% to 70%. It is speculated that the economic poverty among the Korean-American elderly can be attributed to low Social Security benefits (having been low-wage laborers); disqualification for Social Security benefits (falling short of the required 40 quarter participation in the Social Security program); un/under employment; loss of the spouse responsible for support, albeit partial, for their minimal subsistence; an increased cost of living, especially housing costs; and/or poor health that forced them to withdraw from the labor market. Although older persons do not demand much in general, the Korean-American elderly today (about two out of three) have expressed their economic concerns.

Most elderly live in rented apartments. If they are married, about one-half of them live by themselves with spouse. As their children grow older and decide on their careers, children leave. Consequently, the expectation of living in an extended family becomes history. Since 1983, a trend has been noted in that a decreasing number of elderly live with their children, and more and more live alone and/or with friends. Such a phenomenon is being shaped in Korea, due in part to migration, urbanization, industrialization, and the changes in women's social and family roles.

As part of the natural process of human aging, Korean-American elderly also experience poor health in their old age. A majority of the elderly today perceive their health is rather fair or poor. The number of older persons with such an unfortunate, yet realistic, perception has more than doubled since 1983, from 38% to 86%. Some major health related complaints include poor eyesight, diminished hearing, and high blood pressure. Health problems related to nervous and digestive systems appear to be still prevalent among older persons, yet less frequently indicated today as compared to five years ago. According to a WHO study (Andrews et al., 1986), Koreans are likely to develop vision problems in their old age, as well as problems in chewing.

Whenever they need to see physicians, more and more elderly appear to prefer Korean-American doctors. Only 4% of them would like to be treated by herbal doctors who are locally available. For their health care protection, many elderly (about 52%) have medicare and/or medicaid coverage, but the rest indicate no health insurance whatsoever.

In terms of their perception of social service needs, more than 90% of them subscribe to English classes, educational opportunities, and nursing facilities for Korean-Americans. Housing and health related services are second on their wish-list, followed by leisure and social program guides written in Korean. More than two-thirds of the older persons would be helped by employment counseling.

Table 2
Percent of Social and Demographic Characteristics of the Korean-American Elderly

	1983	1987	1988
Median Age:	73	69	66
Sex: Male	51	47	36
Female	49	53	64
Marital Status:			
Married	52	45	35
Unmarried	48	55	65
Religious Affiliation:			
Christianity (Protestant/Catholic)	75	77	84
Average Length living in U.S	5.2 yrs.	6.2 yrs.	8.1 yrs.
Economic Conditions:			
SSI Recipients	47	47	--
Below Poverty	12	30	70
Below Near-Poverty (25% above the Poverty Line)	30	41	73
Income Satisfaction			
Enough	67	38	--
Low	33	62	--

	1983	1987	1988
Housing:			
Own Homes	4	14	7
Rented Apartments	40	70	73
Facilities for Sr. Citizens	7	13	2
Living Arrangements:			
Spouse	50	41	--
Children	62	51	--
Grandchildren	33	11	--
Alone	19	12	--
Relatives	1	1	--
Friends	3	7	--
Health:			
Perceived Health Conditions			
Excellent-Good	62	17	14
Fair-Poor	38	83	86
Health Problems:			
Arthritis	6	10	6
Diabetes	9	11	9
Eye Problem	9	26	22
High Blood Pressure	25	17	20
Kidney	--	--	15
Liver	5	6	3
Neuralgia	21	30	15
Stomach	21	23	15
Others (Skin, Heart, Lung)	17	8	25
Health Care Providers:			
Korean MDs	66	85	88
Herb Drs.	8	5	4
American MDs	19	7	8
Others (Clinic, ER, etc.)	7	3	--
Health Insurance (Medicare/Medicaid)	46	56	52
Social Service Needs:			
Senior Centers	48	86	--
Elderly Housing	52	84	84
Elderly Transportation	13	48	--
Health Edu./Nutrition/ Counseling/Clinic	13	55	86
Korean Nursing Homes	17	69	90
English Class	--	--	97
Citizenship Class	--	--	87
Educational Opportunity	--	--	96
Leisure Time Guide (Korean)	--	--	74
Social Program Guide (Korean)	--	--	75
Employment Counseling	--	--	67

Attitudes of Korean-American elderly toward various psychosocial and political issues were studied in the 1988 research project. All but one (attitude toward marriage) were statistically significant at beyond the .001 level. Levels of satisfaction in their marriage are almost equally distributed, in that almost one in four older persons (24% or 16 individuals) indicate high satisfaction, while about one in five (22% or 15 persons) point to dissatisfaction. The rest are equally divided into 19 each (27%), who signify either their satisfaction level in marriage is normal or they have no opinion.

A majority number of respondents express their normal satisfaction on all variables but two, attitude toward self-confidence and toward U.S. prejudice against race. While none of the sample participants was very satisfied with his/her own self-confidence, only one older person indicated his/her dissatisfaction. Most respondents expressed either normal satisfaction (48% or 33 persons) or no opinion (50% or 35 persons).

The incidence of U.S. racial discrimination is reported to be the most serious problem for the Korean-American elderly. Although the American Civil Rights movements of the 1960's have brought significant progress at the cost of noble lives of many outstanding Americans, the two hundred year old American saga, the prejudice against people of color, still has its residual impact upon lives of newcomers. Needless to say, none of the Korean-American elderly is very satisfied with the American institution of racism, and about one of two (46%) express dissatisfaction. About one of five older persons (20%) and one in three (34%) indicated their normal satisfaction and no opinion, respectively. It is speculated that those individuals who indicate their normal satisfaction meant "as they anticipate" or "as other people of color are being treated". It might be that those who have no opinion have not yet had contact with American racism, in view of the fact that they do not need to, or cannot, be associated with the mainstream of American society. Many of them may have no English language capabilities, so that they only mingle with Koreans for their social, economic, cultural, religious, and/or political activities.

Table 3
Attitudes of Korean-American Elderly

Toward:	Very Satisfied	Dissatisfied	Normal	No Opinion	Chi Square
Children	12	50	4	2	87.5***
Marriage	16	19	15	19	.7
Family Life	23	51	3	2	93.2***
Sex Life	2	53	5	8	101.3***
Social Adjustment	3	46	5	15	68.7***
Self Confidence	0	33	1	35	65.8***
Self	3	37	4	25	48.1***
Leisure Life	3	37	8	21	40.2***
Culture and Tradition	5	40	1	23	56.4***
U.S. Justice System	17	23	6	22	10.5*
Neighbors	0	52	5	12	97.6***
U.S. Prejudice against race	0	14	32	23	32.4***
Koreans in New York	1	40	9	19	49.4***
Americans in New York	4	29	14	21	19.6***
Own Religious Faith	4	41	14	20	53.5***
Future Outlook	3	43	5	18	58.2***
Creative Living	0	36	0	33	69.4***
Immigration Life	1	54	1	12	110.5***
U.S. Government	14	35	6	14	38.2***

$^{*}p<.05$ $^{***}p<.001$

The 1988 study includes behaviors relevant to informal support systems among Korean-Americans. Confidants (with whom older persons would like to discuss and share their concerns, and/or personal matters, and from whom they would like to seek wisdom and advice) are their spouses, children, ministers, relatives, and friends/School Seniors, so-call "sun-bai."

As is in the homeland of Korea, an immigrant's informal support system appears to be built upon friends and particularly around "sun-bai". More than two of five (41%) older persons who need someone with whom to discuss personal matters look to their friends and/or their school seniors. When they need advice, about three of five (57%) elderly also look to the same individuals. Children are a second choice, in that more than one in three (35%) older persons share personal matters with their children, and one in every four (25%) seeks advice. Spouses are the third preference for private talks, but the last choice for older persons seeking advice. Thus, the relationship between husbands and wives in older age can be characterized by: "Secrecy? Yes, thank you; but Advice? No thank you." Perhaps, this type of relationship may still prevail among all marriages of Koreans regardless of their age.

Table 4
Confidants of Korean-American Elderly

Confidants:	Secret Talk (%)	Advice (%)
Spouses	16	7
Children	35	25
Ministers	13	15
Relatives	15	10
Friends/School Seniors	41	57

Policy and Program Recommendations

In view of the increased number of Korean-American elderly who present tangible, yet unattended problems in living, the following public policies and programs are suggested to alleviate relevant issues. Since the U.S. history of Korean immigration is rather young and the issues have been just recently uncovered, the problems are not insurmountable; they are even preventable, when/if there is appropriate and timely intervention. It is indeed an American wisdom to deal with growing social problems facing newcomers from Asia today, rather than to ignore them in the name of "model minority". Policies and programs discussed hereafter are, perhaps, equally applicable to all aged immigrants, as well as others in the same fate, regardless of their race.

First, the income security of older immigrants should be guaranteed. It is true that Social Security programs were never meant to assure sufficient income for older Americans. Nonetheless, most, if not all, retirees plan on it and expect a retirement income from the Social Security Administration. One may have considerable savings and/or liquid assets at the time of retirement, yet inflation and recession can certainly deplete the nest egg in no time. Thus, many American elderly have to face economic poverty for the first time in their lives. Although the SSI program claims to have reduced American old age poverty by more than 60% in the past 20 years, 12% to 14% of elderly citizens still live below the poverty level today.

Due in part to the fact that immigrant elderly earned low wages, did/could not participate in Social Security long enough (less than 40 quarters) to be duly qualified, and the fact that Social Security benefits are contingent upon the amount of one's earnings, most immigrant elderly receive a lesser amount of monthly Social Security benefits in the form of cash payment. Many Korean-American elderly, who worked on part time and/or menial jobs, could not pay into Social Security. Many owners of private businesses paid only their portion of the social security payment, thus their input into the system is smaller, and in return, benefits are also smaller as compared to that of those who had employers' input into the system. Although the number of SSI recipients has increased, many qualified Korean elderly are still unaware of the program, unwilling to apply (though they know how) because they consider it a welfare program and receiving it a personal disgrace and indignity, and/or are afraid of applying for SSI benefits simply because of an alleged rumor that no welfare recipient can petition on behalf of any family member (children primarily) who wish to immigrate into the U.S. Consequently, many poor elderly endure the fate of living in poverty and hide behind an "unpierceable" wall of model minority.

The Social Security requirement of 40 quarters of employment should be individually assessed, in that at the time of immigration, all individuals older than 55 years of age should be given a minimum number of quarters to qualify for Social Security benefits upon retirement. Moreover, by virtue of the fact that the SSI benefit is indeed a privilege of simply being an American citizen or resident, all entitled benefits (if qualified) should be included in regular Social Security checks. Any arbitrary measures of punishment, stigma, discrimination, humiliation, disgrace and indignity should never be applied to SSI recipients, regardless of their color of skin.

A public law that might be called "PTF" (Parents Trust Fund), could be enacted to lighten the burden of children and to alleviate the economic plight of the elderly. The PTF would provide children a tax credit for their contribution to a parent's retirement fund. A maximum amount of tax credit, the age of parents qualified, etc., should be included in the law. Similarly, the IRA (Individual Retirement Account) should be reinstituted for all interested individuals. The more saving, the more income one can have upon his/her retirement, the less the spending by government for the old age programs.

Secondly, the housing cost in America is skyrocketing, in that many American elderly have to gradually resort to substandard housing. The so-called "tenant service program" is charged to protect indigent renters from personal physical and health hazards by living in debilitating and insect-infested apartments. Elderly residents in such quarters cannot work with tenant service workers for fear of being ejected by the apartment owners. Since the tenant service has no provision of post-ejection care, the elderly remain silent. To make matters worse, Korean-American elderly cannot articulate their plight in English, so they have to pretend that they are in a state of perfect contentment.

Albeit limited in resources and budget appropriations as compared to previous years, HUD (Housing and Urban Development) still provides funds for low-income housing. There are several housing projects funded by HUD for Korean-American senior citizens in various urban areas throughout the country. Unfortunately, available housing facilities are far from meeting the existing need. Some projects are racially integrated, and some are ethnically segregated. If integrated, Korean-American elderly have to leave the community where many Korean-Americans live and have businesses, and find social and cultural activities. As a consequence, many do not take the offer because of the fear of an uncertain future in a public housing project. Therefore, it may be fruitful if HUD could build housing projects in areas where ethnic elderly can maintain their quality of life. In addition, the rental subsidy program under HUD should be publicly announced throughout all ethnic communities in their own language and support all qualified individuals.

Thirdly, the United States of America may be the only industrialized and developed country in the world that does not have its own national health policy. Many futile attempts by the U.S. Congress have been repeated since the Kennedy administration in the early 60's and, thus, a national disgrace remains in our backyard today. Regardless of gender, race, social class, or religion, no one should be denied health care. This is a fundamental American value. Moreover, the national health policy should have a provision for health education programs as well as preventive health measures. For immigrant elderly, herbal medicine should be a part of the total health care system, freely open to individual choice.

One health program that is perhaps culturally appropriate for the Korean elderly, or for any ethnic minority elderly, for that matter, would be home health care. As has been demonstrated in the American health delivery system, home health care is much more inexpensive than institutional care. Furthermore, it certainly provides children with opportunities to fulfill a filial obligation to their aged parents as long as they possibly can. Therefore, in order to maintain such an impeccable Asian virtue, and to mobilize and strengthen a culturally prudent health care behavior among Asians, a system of tax relief would be realized (as is being implemented in countries like Singapore and Japan), in that individuals, who provide the care for their older family members, shall receive a predetermined tax credit. Let us be reminded that medicine itself and related socio-political measures, after all, are arts of mercy. Thus, all functional measures of health care and old age income security should be conceived, developed, and effectively implemented.

Fourth, when one compares today's racism with that of two centuries ago, America certainly has made significant progress. Nonetheless, Civil Rights issues remain very crucial and sensitive, and prejudice against people of color still covertly and overtly exists in the minds of the American public as well as in social institutions. In order to protect white supremacy, the majority whites and their institutions have developed an inordinate degree of racial tolerance, but not as yet the spirit of and commitment to human equality and social justice. Fortunately, however, Americans learn from history and there are sincere crusades to eradicate American racism.

The nation has a civil rights policy of which many Americans are proud. The crux of the matter is how to best implement it on behalf of the victims of racial discrimination. For Korean-American elderly, legal service programs are most needed. They need protection from labor exploitation, employment discrimination based on race, age, sex, and language ability, and/or from public abuse of their culture and tradition which may be characterized by non-violent forbearance. Legal service workers should be advocates for the elderly particularly in dealing with dysfunctional and at times inhumane American bureaucrats who are expected to be public servants by properly implementing American public policies. All entitled rights of Americans, including legal residents, should be fully known to all minority races in their own language and through their system of understanding, and all should have equal access to such privileges.

Fifth, as at the dawn of the century when thousands of European immigrants were reaching America's eastern shores, Christian churches are again looked up to for their social ministry. A majority of Korean-Americans are associated with respective churches, and their ministers are considered to be immigrants' confidants. Suffice it to say that churches have spiritual missions, and man should not live by bread alone. Nevertheless, to be spiritual, one must meet his basic needs to sustain his/her physical body which houses the spirit, the mind, and the soul.

When/if churches today take care of their own elderly congregations, problems associated with old age among immigrants will be greatly reduced. Under numerous public and private funding supports, social and health programs can be developed and implemented through the social ministry of churches. One church can provide a variety of services independently, or several churches can jointly serve older congregations by mobilizing and bringing limited resources together.

Conclusion

The bottom line is the fact that American social work is not a charity work which can be sufficiently managed by untrained charity volunteers, or philanthropists, or by any one on the street, for that matter. It is a scientific and professional art that can be developed through professional education and training. Therefore, to serve Korean-American elderly, it is imperative to have professional social workers in every social service agency who are not only capable of developing and implementing social programs, but also very appreciative of and sensitive to cultural diversity. Since language is the soul of people and the primary means of communication, bilingual professional social workers should take leadership in respective ethnic communities as well as in the social welfare institution. Such professionals should be free from politics of organizations and encouraged to be creative and accountable.

Let us be reminded that "do-gooders" are not enough, but the "well-doers" are a necessity. The first basic element of such functional social work for the elderly immigrants is bilingual professional social workers. Find them, train them, and let them be on the move.

References

Andrews, G.R., Braunack-Mayer, Esterman, A.J., A.J., & Rungie, C.M. (1986) *Aging in the Western Pacific: A Four-country Study*. Manila: WHO.

Kim, Jung-Sup (1987). *Korean-American elderly in New York: Problems and pospects*. New York, NY: Korean-American Senior Citizens Society.

Kim, Jung-Sup (1988). *Social welfare program planning data: Priority needs*. New York, NY: Welfare foundation of the Korean Association of New York.

Koh, Yang-Kon (James Y.) (1983) *An exploratory study of filial support and the use of formal services among the Korean aged in New York City*. Tallahassee, FL: Florida State University.

United Nations (1984). *Demographic Yearbook 1982*. New York, NY.

CHAPTER 19

THE ROLES OF GOVERNMENT, FAMILY, AND THE ELDERLY INDIVIDUAL CARING FOR OLDER PERSONS IN JAPAN

Daisaku Maeda

Introduction

It is very difficult to discuss the subject from the global standpoint, as the relationship between the roles of government, family and the elderly individual in caring for older persons differs greatly from country to country. This chapter discusses the theme mainly from the standpoint of the author's own country. Whenever possible, we will try to take into consideration the facts and problems of other countries.

Traditional Family Care Still Functioning in Japan

Many people in developing countries tend to think that in developed countries the elderly are abandoned by their children and live a solitary and miserable life, in general, or are accommodated in institutions. This is not true. Barry D. McPherson of the United States describes the relations of the elderly, their children, and the government in her country as follows:

> Recent demographic changes such as decreased family size, childless marriages, and fewer single adult daughters, combined with an increasing number of middle-aged women in the labor force, have led to a decrease in the availability and opportunity of children to care directly for aging parents. As a result, more social and health care support services are provided by the private and government sectors. Nevertheless, in most societies the family is the first and major resource for the elderly, of whom less than 10 percent are ever institutionalized... (McPherson, 1983).

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What McPherson described is quite true in Japan. Furthermore, Japan preserves the traditional family care of the elderly much more strongly than other industrialized countries. This is mainly due to the fact that her industrialization started much later than Western European countries or North American countries. Thus, even today, the proportion of the elderly that is institutionalized is very small. In Japan, it is only about 1.7 percent. In other words, even in the most industrialized countries, such as the United States and Japan, the overwhelming majority of the elderly live in the community with the support of relatives, friends and neighbors. There is, however, a conspicuous difference between Western countries and Japan. In Western countries, when seriously impaired older persons live in the community, in almost all cases, they are cared for by a spouse. In many cases, a grown child living nearby helps them. It is very rare, however, that a child moves in to the parent's home or takes the parent into the child's home to care for him, when a spouse cannot provide the needed care. Instead, such older persons usually move into an institution.

In Japan, on the contrary, the majority of seriously impaired older persons are cared for by their children living together. Needless to say, a spouse plays an important role, when possible, but the existence of a middle-aged caretaker living together makes it possible for the most seriously impaired persons to continue to live in the community in Japan. A recent nationwide study estimated the proportion of the bedridden (those who had been in such conditions more than 6 months) in the population aged 65 and over in 1984 at 3.1 percent (Ministry of Health and Welfare, 1985a). As shown in Table 1, of all the bedridden elderly, 56 percent were cared for by their spouse, child or other relative in their own homes. The proportion of the bedridden elderly institutionalized in nursing homes was only 23 percent, and the remaining 21 percent were hospitalized.

Table 1
Proportion of Bedridden Old People by Places of Living (65+)

	Hospital	Nursing Home	Own Home	Total (in thousands)
1978 (thous.)	4.8 (13.3 %)	6.4 (17.7%)	2.50 (69.1%)	36.2
1981 (thous.)	7.2 (17.5%)	8.8 (21.4%)	25.2 (61.2%)	41.2
1984 (thous.)	9.9 (20.7%)	11.2 (23.4%)	26.7 (55.9%)	47.8

Source: Ministry of Health and Welfare (1985b)

Another important difference to be pointed out is the very high proportion of elderly persons living together with children in Japan. According to the latest National Census done in 1985, 64.6 percent of the Japanese elderly aged 65 and over live with their grown children. As shown in Table 2, this traditional pattern of living arrangement and family care of aged parents is still fairly well preserved, even in the completely industrialized and urbanized metropolitan areas of Japan where the influence of Western culture is felt much more strongly than in other areas. That is, even in such areas, more than 50 percent of the elderly aged 65 and over still live with their grown children. The same table shows that this proportion is significantly higher in less industrialized areas. Especially in rural areas more than 70 percent of the elderly aged 65 and over still live with their adult children.

It should be noted, however, that the proportion of he elderly living with their adult children has been deceasing very rapidly in the last 30 years, parallel with the industrialization and urbanization of Japanese society. As shown in Table 3, it has been decreasing at the rate of 0.8 percent a year during the last fifteen years. But, it should be noted that it will take approximately 20 years for the proportion of co-living elderly to decrease to 50 percent. In other words, even at the beginning of the next century, approximately 53 percent of elderly persons will be living with their grown children in Japan.

Table 2
Percentage of Elderly (65+) Living with Children in Urban and Rural Areas

	Living Alone	Older Couple Alone	Living with Married Child	Living with Unmarried Child	Others
Japan, Total	9.3	23.0	47.9	16.7	3.1
Metropolitan Areas	13.5	31.1	30.3	21.6	3.1
Other Large Cities (15,000+)	10.3	25.5	45.1	15.9	3.2
Smaller Cities (Under 15,000)	8.7	20.7	51.9	15.9	2.8
Rural Areas	6.7	18.3	56.9	15.0	3.1

Source: Ministry of Health and Welfare (1985a).

The above estimate is made solely by extending the recent numerical trend to the future. But there is another factor which reinforces the above numerical prediction. In 1987, the Section on Aging (Roujin Taisaku Shitsu) of the General Executive Office of the National Government carried out a nationwide survey on the opinions of middle-aged persons about living arrangements of aging parents. According to this survey, as shown in Table 4, still a little over 50 percent of married men and women aged 30-49 answered that one of the children's families should live with aging parents. When they were further asked what they think about the living arrangement of aging parents, if one of them gets frail or dies, more than 80 percent answered that the children's families should live with them. This implies that unless the attitude of the present middle-aged generation changes significantly, which is most unlikely, at least in the next 35 years, the living arrangements of Japanese elderly persons will not change so much as to become similar to that of Western developed countries.

Table 3
Decrease in Percentage of Persons 65 Years of Age and Above Living with their Children

Year	Living with Children	Aged Couple Only	Living Alone	Others	Total	Decreasing Rate of "Living with Children" Per Year	
1970	76.9	12.1	5.5	5.5	100.0		
						0.88	
1975	72.5	15.7	6.9	4.9	100.0		
						0.76	0.82
1980	68.7	18.9	8.2	4.3	100.0		
						0.82	
1985	64.6	21.6	9.7	4.1	100.0		

Note: Persons living in institutions were excluded.

Source: Statistics Bureau, General Executive Office, *National Census*, 1970, 1975, 1980, 1985

Table 4
Opinions of Middle-Aged Persons (30-49)
about Living Arrangements of Aging Parent

Conditions of Parents	Opinions About Living Arrangements of Aging Parents				
	A Son's Family Should Live Together	B Daughter's Family Should Live Together	A&B. Total	Married Child Should Live Separately From Parents	D.K., N.A.
In General	39.7%	11.5%	(51.2%)	36.7%	12.1%
When one of the aging parents gets frail	59.3%	21.6%	(80.9%)	7.1%	12.0%
When one of the aging parents died	60.2%	22.7%	(82.9%)	5.4%	11.7%

Note: National representative sample (1,313) of middle-aged married men and women aged 30-49.

Source: Section of Aging, General Executive Office, 1987.

The Role of Governments in Caring for Older Persons

To repeat, Japan preserves the traditional family care of the elderly much more strongly than other industrialized countries. This is mainly due to the fact that her industrialization started much later than Western European countries or North American countries. As a result, even today, the Japanese civil code still stipulates in the well-known Item 877 that those who are in a lineal relation, as well as siblings, are responsible for the support and care for each other.

It should be noted, however, that the role of the government in caring for older persons is becoming increasingly larger in Japan these days. Let me discuss the enlarged role of our government expressed in the actual administration of public welfare laws focusing on the legal responsibility of children toward aging parents.

Like other industrialized countries, Japan has a set of legislation for the welfare of the elderly. For economically deprived older persons living in the community, Public Assistance Law provides needed financial help, including housing and medical care assistance. Besides Public Assistance, Japan has a special law for the welfare of the elderly which is designed to meet other needs of the elderly, such as needs for institutional care, day care, respite care, home help services, recreational service, etc. In the case of older persons who do not have any relatives to support them economically, needless to say, the goverment takes full responsibility in providing the needed assistance mentioned above.

The issue to be discussed here is the responsibility of the government when the elderly in need of public services have a relative with income which enables him/her to bear financial responsibility, at least partially. As in many other countries, our public assistance law is the strictest with regard to the enforcement of the mutual responsibility to support and care for each other among relatives. It is to be noted, however, that in the actual administration of our Public Assistance Law, the responsibility of children toward their aging parents is regarded to be *relative* in contrast with the *absolute* responsibility of parents toward their young children. The word "relative" means that children who became independent from their parents only need to support and/or care for their aging parents when they have enough financial and social capability after they secure a decent life for their own families. Parenthetically speaking, however, when one lives with one's parents in the same household, one is required to secure the same level of living for one's aging parents as one's own.

In the administration of the Law for the Welfare of Elderly Persons, the responsibility of children toward their aging parents is defined still narrower than in public assistance. The on-going regulation of the Ministry of Health and Welfare on the fees of public community services; i.e., day care, respite care, and home-help service, only requires a child who presently lives with his/her aging parents in the same household to bear the financial responsibility. That is, the regulation requires that the household as a whole should be responsible for the payment of the fee. Thus, a child who lives separately is not required to bear the financial responsibility, however well-to-do he/she is. By the way, the amount of fees for our public community services is quite reasonable. For example, the amount of fee for respite care service is only about 1,000 yen a day which is designed to be roughly equivalent to the cost of three meals.

In the case of the fee for institutional care in nursing homes and ordinary homes for the aged, *only a child who has been living with aging parents when the official decision of placement is done* is required to pay the fee. In addition, the amount of fee imposed on such a child is not so heavy as in the case of the public assistance law. Generally speaking, the financial burden resulting from admission to an institution established under the Law for the Welfare of Elderly Persons is much lighter than when they support and care for their aging parents in their own homes. Needless to say, however, when they do so there are physical and psychological burdens besides financial ones.

Another point the author would like to stress is that not only the financial responsibility but the responsibility to care for aging parents is now defined very narrowly in the actual administration of the Law for the Welfare of Elderly Persons. That is, when aging parents get seriously impaired and need help for their daily living, but a daughter or a son's wife living together is working, she is not required to quit the job to care for them, even if the family is well-to-do enough and her income is not needed. Children can ask the government to provide needed care for their aging parents in a nursing home. They are required to pay only a fee according to the regulation mentioned above. Parenthetically speaking, however, some middle-aged women still quit such professional jobs as school teachers to care for their own mother or mother-in-law. This means that, in spite of modernized administrative regulation of the law, such social pressure with a deep root in the traditional mores that children should care for impaired aging parents in their own homes is still exerting a strong influence in Japan.

Thus, it is now clear that though our Civil Code stipulates the responsibility of children toward aging parents, in the actual administration of public services, the legal responsibility of children is defined very narrowly. Actually, the Government does not compel children to live with impaired aging parents to care for them. When children place them in an institution, the government collects a fee whose amount is usually significantly smaller than the amount they used to spend to support and care for them in their own homes. Only an extremely well-to-do family whose yearly income is over 18.5 million yen (about U.S. $142,000) is required to pay full cost. Actually, the number of such families is very small. At present only about one out of 1,000 families who place their aging parents in nursing homes is paying a full fee.

Here, let me cite two more instances of the changing policy of our government toward children's responsibility toward aging parents both in financial and in actual caregiving. In Japan, there are a number of Keihi Roujin Homes, which can literally be translated as a home for the aged with a moderate fee. This type of home for the aged is designed to serve elderly persons whose income is higher than the ceiling for admission into an ordinary home for the aged. The residents in these homes are only required to pay such direct living expenses as meals, heat, electricity, and so forth. In case their income is not enough to pay the full amount of these direct living expenses, the government gives financial assistance to fill the gap. In addition, the government subsidizes all the indirect costs, such as wages of the employees of the home, expenses for construction and repair of buildings, etc.

In the case of this type of home which, I repeat, is designed to serve those whose income is higher than the ceiling for an ordinary home for the aged, the children are not required to pay anything, even though a substantial amount of running and construction expenses are subsidized by the government. On the other hand, as mentioned above, children who place their parents in ordinary homes for the aged which are designed to serve comparatively less well-to-do older persons are requested to pay the fee according to the fee scale.

Another example is the "Health Care Facility for the Elderly" which is designed to serve elderly persons seriously impaired or suffering from a serious chronic disease and unable to live in the community. The amount and level of care services needed by the patients of this facility are thought to be about the same as those of a nursing home. For this facility, the government pays all the expenses for medical and nursing services in accordance with the Law for Health and Medical Services for Elderly Persons. The patients of this facility are required to pay the rest of the cost; i.e., expenses for meals, clothes, and other items which patients would need to pay when they live in their own homes. In the case of this facility, even spouses who should bear an absolute responsibility to support and care are not requested to pay anything more, even if they are very rich. Many people believe that in the light of our rapidly maturing public pension programs, this facility will become the mainstream of our institutional care service system for the elderly before long.

In short, what I want to stress here is that despite the stipulation in the Civil Code, the present policy of our government is very lenient with regard to the enforcement of the legal responsibility of children to support and care for their aging parents and, that in the future, they will become more lenient and eventually the responsibility of children toward aging parents will become a moral one rather than a legal one.

Public Services for the Impaired Elderly in Japan

In a previous section of this chapter, I discussed the legal aspects of the relationship between the role of government and the responsibility of relatives in Japan, paying special attention to that of children. Here let me briefly describe what out National Government is doing now for the impaired elderly and their caring families.

The national programs are all administered by local governments with subsidies from the national government. In addition to these programs subsidized by the national government, a number of local governments have established their own programs, although, generally speaking, their effects are limited when compared with those of the nationally supported programs.

Institutional care

As of 1986, the total number of beds in all kinds of institutions for the aged (including those for ambulant but frail elderly) was 212,900. This is roughly equivalent to 1.65 percent of the population aged 65 and over. The proportion of the institutionalized elderly is still remarkable small compared with other developed countries, though the proportion of the elderly hospitalized seems to be comparatively larger in Japan than in other industrialized countries, as will be discussed later in this chapter.

One important issue to be discussed here is whether the number of institutions for the elderly is enough to meet the needs. Generally speaking, in large metropolitan areas, such as Tokyo, Osaka, and the like, the shortage is serious, especially the shortage of nursing home beds is very acute. The impact of this shortage will be discussed later.

Community services

Japan had no public home care services before 1962, when the National Financial Support Program for Home-Help Services was established. Since then, three national programs have been established: Provision of Special Equipment for Bedridden Older Persons in 1969, Short-Term Stay Service in 1978, and Day-Care Service in 1979.

a) Home help services

In 1970, the number of home helpers throughout Japan was 6,100 (full-time). By 1987, the number had increased approximately four times, to 23,500. During these seventeen years, the ratio of the number of home helpers for persons aged 65 and over had increased from one per 1,210 to one per 530. Nevertheless, Japanese home help services are still greatly behind those of other developed countries.

b) Provision of special equipment for bedridden older persons

This equipment includes special beds, bathtubs, hot water heaters, mattresses, and so forth. This service is said to be almost enough to meet the explicit needs.

c) Short-term stay service

Short-term stay services for the bedridden elderly are fairly well-developed in Japan. In 1987, the national government assigned a subsidy for local governments to serve approximately 41,000 bedridden older persons throughout Japan. They can stay a week in a nursing home for any reason including giving respite to a care taker. The length of stay can be extended when necessary.

d) Day-care service

In 1986, the national government announced a long-term goal for its development in comprehensive long-term social security and health and social service programs for the aging society. In this announcement the national government revealed that the goal for the development of day-care services is to establish 3,000 day-care centers throughout Japan in the near future. The program further says that in the long run approximately 10,000 such centers should be established including small-scale branch centers. In 1987, approximately 500 such centers have already been established including the ones not supported by the national subsidy. Day-care services are expected to provide rehabilitation and reactivation services and thereby enable elderly persons to become independent, or at least less dependent, in their daily living, which will alleviate the strain on caretakers.

e) Loans to caretakers who build or remodel their homes

This program is provided for caretakers who build or remodel a house with an independent room for older parents, or add such a room to an existing home.

f) Tax deduction or exemption

Income tax credit is given to all taxpayers, regardless of income, who are supporting older persons aged 70 and over, whose income is below a certain level. When the old person is the taxpayer's or the spouse's parent and lives in the same household as the taxpayer, the caretaker is eligible for additional tax credits, and when the degree of impairment is very serious the deductible amount is further increased. Similar credits are also given for local taxes. The amount that is deductible, however, is rather small when compared to the amount actually needed to support an old person in the home. Therefore, this program should be regarded as a means of encouraging family caretaking rather than a real support.

Here, let me briefly sum up the effects of our public services in the total context of the provision of the care for the impaired elderly in Japan. Generally speaking, there is an acute shortage in our provision of institutional care, especially in large metropolitan areas. As a result, as will be reported later, many seriously impaired older persons live in the community without adequate care. Neither are our community services well-developed yet. Thus, despite the very lenient policy of our government about the responsibility of relatives, in many cases they cannot help but care for their seriously impaired spouse or parents in their own homes, without the help of public community services. When they cannot care for them in their own homes for various reasons, impaired older persons are hospitalized. Thus, the proportion of hospitalized older persons is very high in Japan. It should be noted, however, that the amount of fee for hospitalization is not very expensive in Japan due to universal public medical insurance. This is another reason why the proportion of hospitalized older persons is very high in Japan.

Attitude of Middle-aged Japanese Persons on Family Care of the Bedridden Elderly

In a previous part of this chapter, the author stressed that unlike Western countries, the majority of bedridden older persons are cared for by their spouse and children in their own homes in Japan. Some Westerners have attributed this to the limited amount of available nursing home beds. The shortage of beds in institutions, however, seems to be only a minor reason why the majority of Japanese old people are cared for by their families.

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The recent nationwide survey of the opinions of middle-aged married persons also studied children's plans for the care of their parents when they become bedridden. According to the survey, approximately two thirds answered that the child or the child's spouse would care for them. The proportions of respondents who answered that the parent's spouse should, was 19 percent in the case of the husband's parents and 14 percent in the case of the wife's parents. Less than 7 percent answered that they were planning to depend upon resources other than family members; i.e., a paid housekeeper, public home help services, nursing homes, etc. (Table 5). Thus, it is clear that in Japan the majority of middle-aged persons still firmly believes that care of bedridden older parents is the responsibility of their children.

However, there is a great gap between attitude and fact. As shown in Table 1, in Japan almost half of the bedridden old people, are hospitalized or institutionalized. Even if we admit that a number of those bedridden old people do not have children, or are too seriously impaired to be cared for by the families, or whose expected caregiver is too old or not healthy enough, this gap between attitude and reality means that many middle-aged persons do not provide needed care for other reasons; e.g., an expected caregiver might choose to continue her career rather than to sacrifice her future life, or a bedridden older person might prefer to go to a hospital or nursing home rather than to be cared for by his/her children in fear of being too much of a burden, or children might not want to give needed care because of difficult human relations.

Table 5
Children's Plans for the Care of Their Parents When They Become Bedridden

Planned Source of care	For Husband's Parents (N = 1,017)	For Wife's Parents (N = 1,019)
Parents' spouse	18.6%	13.6%
Respondent himself/herself	25.0	9.6
Respondent's spouse	17.5	7.3
Brothers, sisters & their spouses	24.3	49.8
Other family members or relatives	3.4	8.0
Sub-total	88.8	88.3
Other resources (paid houskeepings, public homehelpers, nursing homes, etc.)	6.5	4.4
Don't know	4.8	7.2

Source: Section of Aging, General Executive Office, 1987.

Change in the Roles Played by Children

Reference was made to the gap between the attitude and real behavior of middle-aged Japanese persons in relation to the care of bedridden parents. However, the avoidance of a culturally expected role is made possible by the development of formal support and care services. A similar phenomenon can be obseved in other aspects of relations between the elderly and their adult children. Comparing two nationwide studies on the care of older parents done in 1974 and in 1983 (Section on Aging, 1974; 1983), one finds that the proportion of children (married, middle-aged male children) providing economic support to their aging parents decreased as follows:

	1974	1983
Children aged 35-39	41%	36%
Children aged 40-44	42%	40%
Children aged 45-49	48%	42%

To the question, "Why they do not provide financial support for aging parents?" (in the 1983 survey), 54% of those who were not doing so answered that their parents were well-to-do enough and did not need such support. During these nine years, Japan's economy developed very much, and the income of these middle-aged men had improved substantially. Therefore, the reduced proportion of economic support to aging parents reflects the greater financial independence of the elderly brought about by the development of our public pension programs.

The importance of the role of adult children in health care has also changed greatly these days. As shown in Table 1, in 1978, 69 percent of bedridden old people were cared for in their own homes (Ministry of Health and Welfare, 1985a). The same survey done only 6 years later, disclosed that this proportion was reduced to 56 percent.

Causes of Decline in Family Role in the Care of Aging Parents

As I have pointed out several times in this chapter, the pattern of traditional family care of the elderly is still well maintained in Japan. But it is also true that there has been a significant decline in such family care in the past several decades.

At least four factors should be considered as causes of this decline in the context of social situations in Japan:

1) change in socio-economic structure of Japanese society as a result of rapid industrialization and urbanization;
2) demographic changes;
3) decreased capability of families to care for their aging parents; and
4) development of formal support and care services.

1. Impact of rapid industrialization and urbanization

Japan has been experiencing rapid industrialization and urbanization since 1955. At that time, the proportion of the population who were engaged in agriculture was approximately 41 percent. This proportion decreased to approximately 9 percent in 1985 (Statistics Bureau, General Executive Office; 1955; 1985). This reduction of the agricultural population had a profound impact on the socio-economic structure of Japanese society. In Japan, and also in other East-Asian countries, when the head of a household is engaged in agriculture, all the adult members of the household, including the elderly, also work together in agricultural production to help the work of the household head. In other words, all the household members of East-Asian farmers produce collectively and, at the same time, consume collectively. In a society where this type of household is predominant, it is quite natural and convenient for all family members to live together in the same household.

In industrialized societies, where an older generation and a younger generation are both engaged in secondary or tertiary industry, the two generations generally have separate incomes. In addition, because of the different life styles of the two generations caused by different occupations, in many cases it is more natural, and above all more convenient, for both generations to live separately.

Secondly, industrialization has brought about much more geographical mobility of working populations. In industrialized societies, people change their jobs much more frequently than before. Even when they remain in the same firm, most of the employees are frequently forced to move to other industrial areas for various reasons. In such cases, aging parents tend to prefer to remain at the original residence rather than move to an unknown place with the child's family in order to continue to live together.

Thirdly, in our industrialized areas, housing for workers is, generally speaking, not large enough for two generations to live together.

Last, but not least, the awakening of a sense of selfhood among the general public aroused by higher education, higher living standards, and the influence of Western industrialized countries has also played a very important role with regard to the change in living arrangements of the elderly in Japan. That is, these days an increasing number of both the older and younger generations prefer to live separately from each other just for the sake of personal independence and freedom.

All in all, Japanese society is now in a conflict with regard to the family care of elderly parents, where the impact of traditional culture and that of industrialization and modernization exist side by side.

2. *Impact of demographic changes*

One feature of Japan's recent demographic changes is an increase in the number of unmarried and/or childless old people along with an increase in the total size of the aged population. Moreover, because of improvements in the general standard of living as well as in the medical sciences, the number of very old persons, aged 80 years or above, has increased significantly, as shown in Table 6. The more advanced age of dependent older parents means that the age of their caretaking children is also higher. In many cases children, themselves, are already old and their own health is not good enough to provide needed care.

Table 6
Index of Increase in Number of the Older Persons, 1950-2020

Age	1950	1975	2000	2020
60-69	100	190	360	371
70-79	100	214	499	765
80+	100	323	1,193	2,398

Source: Statistics Bureau, General Executive Office National Census, 1950, 1975, and Institute of Population Problems, Ministry of Health and Welfare, 1986.

3. Decreased capability of families to care for aged parents

Several social factors have contributed to the decreased capability of families to care for aging parents. First, a great migration of the younger generation from rural to urban areas has occurred. On the urban side, the development of industry brought about a dispersion of industrial areas. Thus, persons who were born and raised in urban locations often find it difficult to get a job in the urban area where their older parents live. As a result, in urban as well as rural areas, the proportion of old people living alone or only with their spouse has increased.

Another social factor is the growing number of working women. Many of the married, middle-aged women who were once the most dependable caretakers of dependent older parents are now working outside their homes.

Finally, the number of children in Japan has decreased rapidly since 1950. As a result, persons with fewer children are now gradually entering the aged population. Obviously, when old people have fewer children, their chances of depending on them are reduced. This factor will make the need for services for old people, both community and institutional, more acute in the near future.

4. Development of formal support and care services

Theoretically speaking, formal support and care services were developed to cope with the various problems the elderly and their families are facing in the industrialized society of present day Japan. However, as economists frequently point out, supply arouses demand. Although the development of various forms of formal support and care services in recent years has made it possible for people to depend upon them with regard to the care of their aging parents, it should be stressed that the original aim of the development of formal support and care services was to solve or at least alleviate the problems of the elderly and their caring families. The present situation of our formal support and care services was discussed in a previous part of this chapter.

Difficulties of families Caring for Impaired Aging Parents

The impact of the demographic and social changes described above had been so strong that the recent development of formal support and care services could not fully meet the expanding needs of the elderly and their families. As pointed out before, impaired elderly are frequently cared for by families whose capability for giving needed care is not sufficient. In these cases, the quality of care is very poor and, at the same time, the sacrifice of the caring family is very great. Without a doubt, institutional care should be provided in some cases. In other cases support from outside sources can effectively complement the function of the family and, as a result, the level of care will become adequate and the family's burden will become lighter and more bearable.

To effectively plan and implement social services for impaired elderly, knowing who is actually caring for them, and under what conditions, is vitally important. Recently a number of such studies have been conducted in Japan. The results of three of these investigations deserve special attention.

In 1987, a nationwide survey of the opinion of middle-aged persons (couples) about later life and the care of the elderly was performed (Center of Life Insurance and Culture, 1987). According to this survey, 44 percent of husbands aged 40 to 59 and 48 percent of wives of the same age bracket answered that they were caring or had cared for impaired elderly in their homes. Of these, 46 percent were the very severely impaired elderly who were provided with total care, including the changing of diapers. The same survey also disclosed that 46 percent of middle-aged husbands and 50 percent of middle-aged wives were caring or had cared for elderly with serious symptoms of senile dementia. Among these elderly the following mental symptoms were observed:

Symptoms	% of the elderly
Disorientation for person	45
Disorientation for time	35
Delusion	29
Hallucination	25
Delirium	24
Loitering	21

Generally speaking, care of such mentally impaired elderly imposes very heavy burdens on caretaking families. According to a study of these family burdens (Tokyo Metropolitan Institute of Gerontology, Sociology Department, 1987), major burdens expressed by primary family caregivers of the demented elderly were as follows:

Burdens	% of caregivers
Anxiety about one's own health	78
Anxiety about care in the future	77
Mental exhaustion	76
Lack of time for hobbies, learning, etc.	64
Desire to place the elderly in an institution	61

This study also revealed that significantly heavier burdens were laid on primary family caregivers when they were in poor health, when they did not have any assistant caregivers in the same households, and when delirium and aggressive behaviors were more frequently observed on the part of the elderly.

The question of who is caring for bedridden older people is answered in Table 7, which describes caretakers in relation to the gender of the bedridden elderly. As seen in the table, 61 percent of bedridden older men are cared for by their wives, and 22 percent are cared for by their son's wives. On the other hand, 50 percent of bedridden older women are care for by their son's wives, and 28 percent are cared for by their own children.

Table 7
Caretakers of Bedridden Older Persons

Caretaker	Bedridden Males %	Bedridden Females %
Spouse	61.0	11.4
Children (including both sexes)	10.8	27.7
Son's wife	21.7	50.4
Grandchildren (including both sexes)	0.8	2.7
Others, unknown	5.7	7.8

Source: National Council of Social Welfare (1979).

These figures reveal several very serious problems. First, the average age of the caretakers is high. About one fourth of the caretakers of bedridden old people are aged 60 and over, including three percent who are aged 80 and over. Second, the majority of caretakers are sons' wives or married daughters, who are generally at the prime stage of life and are busy with many duties such as work and the care of their own children. Third, in some cases, bedridden elderly are cared for by unmarried sons or daughters who are usually also working full time. It is often very difficult for the caregivers to have the opportunity to marry, and because of the social pressure dictating that children should take care of their aged parents, they seldom place their parents in institutions.

Further evidence of the difficult conditions experienced by Japanese caretakers can be seen in Table 8, derived from a study conducted in Tokyo by the Sociology Department of the Tokyo Metropolitan Institute of Gerontology in 1981. This table describes the care of physically impaired old people living in the community in terms of the degree of difficulty experienced by care taking families.

Table 8
Prevalence Rate of Impaired Older Persons by Degree of Physical Impairment and by Degree of Difficulty of Caring Families

Impaired's Degree of Impairment	Degree of Difficulty of Caring Families: Very Difficult	Slightly Difficult	No Difficulty	Unable to care or not caring	Degree of difficulty unknown	Total
Most seriously impaired	6.8	2.6	--	--	0.2	9.6
Seriously impaired	16.8	2.8	--	1.4	--	21.0
Moderately impaired	20.5	0.1	0.2	7.2	- -	35.9
Slightly impaired	5.4	1.2	0.2	6.5	0.2	13.5
Totals	49.5	14.7	0.4	15.1	0.4	80.0

Note: The number in each cell indicates the prevalence rate of the category per 1,000 persons aged 65+.

Source: Tokyo Metropolitan Institute of Gerontology, Sociology Department (1983).

As can be seen in the bottom line of the table, well over two thirds of the impaired elderly are cared for by families whose degree of difficulty in caretaking is very serious. Even among the most seriously impaired older persons who are completely bedridden and/or totally incontinent, more than half are cared for by families whose degree of difficulty is very serious.

From the viewpoint of ascertaining the unmet needs of impaired elderly and their families, the most seriously impaired older persons cared for in a family with the most serious difficulty require special attention. As shown in Table 7, these cases account for 6.8 per thousand of the population aged 65 and over who are living in the community. It is quite clear that these persons should be institutionalized as soon as possible for their own well-being as well as for the well-being of their caretakers. As this study was done seven years ago, the proportion now might be a little bit smaller, owing to the development of the institutional services mentioned earlier in this paper. However, as the availability of nursing homes is still seriously inadequate in large metropolitan areas, we are quite sure there are still quite a number of such families waiting for a long time for admission into nursing homes. In many of these families both the impaired elderly and their caretakers do not desire institutionalization, because they think that care to the aging parents should be given by their children (including the son's wife) in their own homes.

In Table 8, the proportion of families whose degree of difficulty in caretaking is very serious accounted for more than 60 percent of all families caring for the impaired elderly. If one takes into consideration those families for whom caretaking conditions were slightly difficult, almost four-fifths of the care-taking families reported some difficulty in caretaking.

Not all of these families need external care services immediately. It is quite likely, however, that most of the families caring for the most seriously impaired older persons, will need some form of outside support in the near future. Because community services to support these families are not very well developed, the hardships that they experience are often very serious. The term "family care" has a beautiful and noble connotation, but in many cases, it is accompanied by the painful sacrifice of the caretakers, and the quality of care is frequently poor.

Table 8 shows the results of an objective measurement of the needs of impaired elderly and their families. In the same survey we also studied the subjective needs in these cases and found that the number of respondents who expressed needs subjectively was much smaller than the number of cases diagnosed objectively as having needs. For example, our study shows that less than half of the families who were judged as needing home help services stated that they wanted that service. However, these implicit needs will no doubt become more and more explicit as the number of impaired older persons increases as our society continues to change. The rising number of married middle-aged women anticipated to enter the labor force in the future is likely to be especially important in the shift from implicit to explicit needs.

Thus, it is urgently necessary that we develop various types of institutional and community care services for the impaired elderly and their families as well as support and encouragement programs for those families.

Conclusions

This subject of care for older persons has been discussed in the context of contemporary Japanese society which has been experiencing an unprecedented rapid change since the 1950s.

It is popularly known that Japan preserves the traditional family care of the elderly much more strongly than other industrialized countries. It is also to be noted that even today the Japanese Civil Code stipulates that those who are in a lineal relation, as well as siblings, are responsible for supporting and caring for each other. But in the actual administration of the Law for the Welfare of Elderly Persons, the government is very lenient with regard to the enforcement of this responsibility.

According to a recent national survey, approximately 50 percent of Japanese middle-aged persons indicated that they are ready to provide needed care for their parents, when they become bedridden. There is a significant gap, however, between the attitude and the real behavior of middle-aged persons. The proportion of bedridden persons cared for by their families is now only slightly over half of such persons which is much smaller than the findings of research on attitude implies. It is also to be noted that the proportion of the elderly living with their grown children has been decreasing significantly in these several decades.

To cope with the impact of drastic demographic and social changes, the government has been developing various kinds of formal support and care services these days. However, they cannot fully meet the rapidly expanding needs of the elderly and their families. Thus, impaired older persons are frequently cared for by families whose capability for giving needed care is not sufficient. In these cases, the quality of care is very poor and, at the same time, the sacrifice of the caring families is very great. In the light of predicted sharp decline of family care in the future, it is clear that governments at all levels should undertake much heavier and wider responsibility for the care of older persons.

References

Center of Life Insurance and Culture (Seimei Hoken Bunka Sentaa), *Rougo Seikatsuto Kaigoni Kansuru Chousa_* (Survey on Later Life and the Care to be Given), Tokyo 1987.

Institute of Population Problems, Ministry of Health and Welfare, *Estimated Future Population of Japan*, Tokyo, 1986.

McPherson, B. D., *Aging as a Social Process*, Butterworths, Toronto, 1983.

Ministry of Health and Welfare, *Kousei Gyousei Kiso Chousa Houkoku*: Showa 60-nenban (The Report of Fundamental Survey for Health and Welfare Administration, 1985 edition), Tokyo, 1985a.

Ministry of Health and Welfare, *Kousei Hakusho: Shouwa 60-nenban* (White Paper on Health and Welfare Administration, 1985 edition), Tokyo, 1985b

National Council of Social Welfare, *Roujin Kaigo Chousa Houkokusho* (Report of the National Survey on Caretakers of the Elderly), Tokyo, 1979.

Section of Aging (Roujin Taisakushitsu), General Executive Office, *Rougono Seikatsuto Kaigoni Kansuru Chousa* (Survey of Opinions about Life After Retirement and the Care to be Given), Tokyo, 1987.

Section of Aging (Roujin Taisakushitsu), General Executive Office, *Roushinno Fuyouni Kansuru Chousa* (Survey on the Support and Care of Aged Parents), Tokyo, 1974, 1983.

Statistics Bureau, General Executive Office, *Kokusei Chousa* (National Census), Tokyo, 1950, 1955, 1970, 1975, 1980, 1985.

Tokyo Metropolitan Institute of Gerontology (Sociology Department), *Zaitaku Shougi Roujinto Sono Kazokuno Seikatsu Jittai, Oyobi Shakaifukushi Need-ni Kansuru Chousa Kenkyu (3) -- Toukyono Shitamachino Baai* (Study on the Needs of Impaired Old People and their Families (3) -- in the case of the older sections of Tokyo, 1983.)

Tokyo Metropolitan Institute of Gerontology (Sociology Department), *Chihousei Roujinno Kazoku Kaigoga Motarasu Eikyou Oyobi Futanni Kansuru Chousa* (Survey on the Burdens of Families Caring for Demented Elderly); Several articles will be published in Shakai Rounengaku *(Journal of Social Gerontology),* No. 28, January, 1989.

CHAPTER 20

AN OVERVIEW OF AGING IN THE WESTERN PACIFIC

Gary Andrews

Almost every lecture on aging that I have ever given, and the vast majority of those I hear, begin with demography. We hardly need reminding of the impact that aging is making on a global scale. Without worrying too much about the figures themselves, which really are virtually incomprehensible to the human mind, one is struck by the rapid increase, the unprecedented increase, in historical terms, of the total world aging population. It was thought that this was an issue primarily for the developed, Western nations of the world until recently. It is now apparent that every country and every region of the world is experiencing this phenomenon, perhaps some less rapidly than others. But towards the end of this century, and well into the next century, the increases that will occur in the proportion of elderly people in populations -- particularly in the developing world -- will follow unprecedented trajectories.

Indeed, if one looks at countries like Japan, you can see changes in the demographic structure of Japan which will move it in just a few decades over a series of changes that took place in Western Europe over a century or more ago. It is these changes that brought about a very significant change in the global picture generally, about 1980. Before 1980, if you look at the world as a whole, the elderly population (that is, people sixty and older) was about equal when comparing the developed and developing countries of the globe. In 1980, the developing countries overtook the developed world and will continue to do so, so that a very significant majority of the world's elderly will live in the countries that we now call developing through the year 2000 and well beyond.

AN OVERVIEW OF AGING IN THE WESTERN PACIFIC

Why should we talk about Asia (and here we combine Asia and Oceania)? It is because, of all of the regions of the world, it will account for the most significant increase. While there are increases throughout all of the regions, by far the greatest total numbers and the greatest proportional increase will be in Asia. Lest we forget the scale that we are talking about, let us look at the numbers of countries throughout the world that will have more than 2 million people age sixty and over. Indeed, by the year 2000 there will be one country with over 100 million people in this category, and there is no surprise in knowing that is China. By the year 2035 there will be two, the other one being India. But if one just looks at the total number of countries where there will be more than 2 million, it jumps from about 22 at present to some 39 in the year 2035.

So the region is an incredibly large, incredibly diverse, part of the globe, containing countries such as Australia and Japan that are relatively highly developed; countries like China and Burma that have opened their doors to the West only in relatively recent decades; rapidly developing countries like Korea; and countries in varying stages of socio-economic change and development. All of them experiencing in the main, the impacts of urbanization, of modernization, of changes in social values, of changes in socio-economic circumstances, and all experiencing significant increases in the total and proportional elderly population. We are coming to think of Asia and Oceania more in these terms.

Just to remind you again, this is a region of great diversity and, as an example of some of the differences one finds in this region of the world, I refer to the United Nations figures for expectation of life at birth for 1980-85 and projected for 1995, 2000, 2020 and to 2025. There is quite a significant variation and there is expected to be quite a significant change over the coming decades. What I want to report on here is a World Health Organization collaborative study, which began in 1983-84 and involved four countries of the Western Pacific: the Republic of Korea, Malaysia, the Philippines, and Fiji. I am often asked why those countries were chosen, and the simple answer is they chose themselves. They were countries that expressed an interest to the World Health Organization in such a study being undertaken. The objectives for the study were fairly straightforward and simple, but perhaps the most important one was this exercise of awareness-raising.

Let me confirm what Harold Sheppard has stressed; that indeed these developing countries have only recently begun to show a real interest in the importance and impact of aging in social and economic development, and health and welfare terms. It is very important to that process to provide them with information that is directly relevant to their own countries and to their own concerns. We felt that doing these studies was important in having an impact on researchers, practitioners, and policy makers by getting them involved in looking at the situation in their own backyard, as it were, rather than referring to abstract global figures, or the data that were obtained from countries that are really very different from their own. It was a pilot exercise aimed at getting some experience at doing survey research on aging in a developing world and on Asia in particular.

I must say that we did learn a great deal and, I suspect in a number of ways if we were to have gone about it again, we might well have gone about it differently. But the experience was extremely important. It was an important exercise in identifying areas for more in-depth research, and I am glad to report that in a number of the countries, further research has been done by the teams we involved in the beginning. We contributed to a global data base on aging, and we did provide some information relevant to the formulation of policies and programs for the aged.

The study consisted of a review of existing data and the most notable thing was that there was very little. Many of the countries, although they collected information from their hospitals (for instance, morbidity statistics), would just lump all of those age 50 and over together. There was no separate enumeration of the older population. Much of the census data that were available were not generally broken down in any detail for the aging population. We carried out a population survey, a household survey. And to add some flesh, as it were, to the bare statistical bones in each of the countries, there were a number of selected case histories carried out.

In a study such as this, the real work is done not by people involved in coordination, or in the overall planning, but by the investigators in each of the countries. We were particularly lucky to have some really excellent people involved in this work. The quality of the work in the end depended much more on their capacity than on mine or anybody else's

The survey content is pretty standard; it includes demographic information and family structure, living arrangements, economic resources, education, physical and mental health activities, living habits, social activities, health care utilization, and housing. We did some very simple assessments, because the budget available to us did not allow us to do anything more sophisticated in terms of assessment of the individuals or clinical examination. There was a simple literacy test that looked for visual acuity, and we checked for cataracts. There was a standardized hearing test, and some scales that included informant and interviewer assessments of social and economic resources, and mental and physical health of the subject.

The demography of these countries was similar to that of the developing nations generally. That is, at this point in time there is a relatively small proportion of people in the population in the age group that we are interested in. That proportion significantly increases to the end of this century, and that increase goes on and accelerates quite markedly beyond the year 2000. Of course, the more significant thing in practical terms than the straight percentages is what this represents in total numbers -- in absolute numbers -- more than doubling of the older population. And just as in the Western World, the increase will be greatest in the oldest-old.

Our survey was based on random samples of the population aged 60 and over from representative locations. We did not try to obtain nationally representative samples; the scale of the study would not have allowed that. The sample sizes for individual countries were relatively small in this initial study. But all in all, we ended up with 3,603 respondents from all four countries. In Malaysia, 1,000 respondents; Republic of Korea, 977; the Philippines, 830; and in Fiji, 796. The sampling was so arranged as to obtain approximately equal numbers from urban and rural areas.

There was enormous variation in the attitudinal and cultural framework in each of these countries. Just to give an example, it was necessary to translate the questionnaire into eight different languages. Even if you took the translation for the Indian population, for instance in Malaysia, it was necessary to have a different translation for the Indian population in Fiji. For the administration of the questionnaire in the rural areas of Malaysia, it was necessary to select interviewers who knew or were able to use the 12 local dialects that applied in the region from which we sampled.

We discovered a great deal about the problems and challenges of doing cross-cultural research, of which there are many examples I could give you. Perhaps one of the most difficult areas is in getting any kind of assessment of mental health. We used fairly standardized instruments that have been used in many other studies, mostly in the Western World, the usual kind of screening questions one asks, for instance, to detect if there is any suggestion that there might be psychotic illness in the respondents you are interviewing. A standard sort of question, paraphrased, asked about voices and hearing voices from inanimate objects and so on. If you ask that question in Malaysia, you will find that an extraordinarily high proportion of the elderly population appear to be paranoid psychotics because, of course, the spirits are everywhere; they're in the rivers, they're in the trees. They're even in the buildings and they often talk to you. Indeed if they don't, in that particular culture, particularly in the rural areas, there is probably something peculiar about you.

A rather silly question in the scale asks whether you receive odd messages, strange messages, from your television set. You might be interested to know that 60 percent of the older population in the Republic of Korea receive strange messages from their television set.

Any of you who, like I have, have experienced television in Korea, would see just how true that is! So it is not a very effective screening test. There are many other examples. In the cognitive testing area, for instance, we searched very hard to find standardized instruments that we could use cross-culturally, and we were in part, successful. But one of the items which I thought would be quite useful (and many of you will be familiar with it) is one where you draw two interlocking five-sided figures and it is scored according to the accuracy with which the individual draws the figures, etc. It is a very nice little test that measures aspects of cognitive function and it seemed to be pretty culture-free, except that in the rural areas (again, Korea and Malaysia), we discovered that many of the people had never held a pencil in their hands before. So asking them to draw something on a piece of paper was quite an anathema. There were many problems like that.

But enough of the problems. Let us look at some of the data. I want to give you some impressions. We were fortunate in that there had been an 11 country study carried out in Europe, and from the data that were available from some of those 11 countries, we were able to make general comparisons in terms of the kinds of data we obtained from our four countries and the experience in Europe. For most purposes I stress you should not lump countries together in this kind of study. But just to give the overall impressions of the trends, we did this in a number of areas, but with some qualifications. We found, not surprisingly, great similarities, for instance, in the basic demographic features of the population great. For instance, the proportion of married respondents showed a decline through old age that was exactly parallel to that which was obtained, and indeed virtually along the same lines, as that in the European states. The reason for this, of course, is the rate of loss due to death, to widowhood, and of course, the impact is much greater upon the females who tend to outlive the males significantly, particularly at the upper age ranges.

However, when we look at the proportion of people who live with children, there is a very striking difference. Generally, the proportion of elderly people in Europe living with children is very low, whereas for our populations it was universally much higher. Likewise, there is some indication that the extended family situation -- the proportion living with four or more, and the proportion living in multigenerational households -- was very much higher. In contrast, the proportion of elderly people living alone in these Asian and Pacific countries was extremely small -- 5 percent in the highest case, mostly around the 2 percent mark. But in Europe, and to an increasing extent elsewhere in the developed world, the typical elderly person is the aged female who lives alone. This is almost unheard of in the developing world at this point.

In terms of overall health status, we asked the usual kinds of questions about how people felt about their health, self-perceived health, how they perceived their health in relation to others, and so on. Generally, although there was some variation between the countries, we saw a fairly healthy and robust population without really very much decline over time with age -- just a little at the extremes. When compared with the European studies, this tended to suggest, as indeed some of the other data did, that we were seeing a more robust and generally healthier elderly population. In some ways, this might be seen as a positive thing, but our evidence suggests that what you are seeing is the result of selective survival. As life expectancy increases, and more and more of the populations survive into old age, and particularly as the survival of the elderly population itself increases, so you will see the proportion of those with morbidity, with problems with disability, and dependency increase.

There clearly is a need to put emphasis on prevention, on the maintenance of health and well-being of this population, particularly as it grows in the future. This sort of picture was borne out by looking at activities of daily living (ADL) where the vast majority of this population were able to carry out all of the activities that were inquired about. The drop-off in the capacity to do all the ADL items is not very great, and occurs only at the extremes of age. We have come to believe now that asking about activities of daily living is not a really very fine measure of physical performance and abilities. There are other measures that are better and we have used those in subsequent studies.

When we looked at the sort of classical problems that tend to be associated with aging, in health and physical terms in particular, we found, not surprisingly, an association with age, such as difficulty in walking. Generally there is a fairly evident increase in the proportion with difficulties in mobility, and this is borne out in other ways in the analysis of the results. Likewise, in proportion to experiencing hearing problems, sight problems are very prevalent in these populations, and not such a marked difference in age, regarding difficulty in chewing most commonly due to denturelessness.

The picture we generally obtained through these results, and through looking at morbidity findings in these countries, was that the patterns associated with aging, the patterns that one comes to expect from the many studies that have been done in Western society, now are much the same. The proportion of people experiencing various problems is different, as I said, reflecting the different nature of the elderly population and the developing world at the present time. But the patterns seem to hold up consistently.

Overall, we found a number of things. For example: there were some people who experienced various kinds of problems who were either unaware of the problem or unaware that anything could be done about it. This is just an example of the significant minority of people who tested as having poor hearing, but who did not suggest they had any need of a hearing aid. Sometimes that merely reflects accessibility. In terms of health habits and behavior, smoking was interesting in that when compared with the European findings, there was a pretty high rate of smoking, particularly through to the extremes of old age. This was consistent for all countries. One might wonder, as the various antismoking campaigns begin to have their impact on the Western World, whether the tobacco companies might well be looking for new markets in the developing world. I read recently that the problem is a sort of a conflict in conscience, I suppose, of a nation that is trying to persuade its members to give up smoking and lead a healthier lifestyle, while pushing very hard to increase the export of the tobacco crop. Someone will work out how to resolve that dilemma in due course.

Drinking rates were generally somewhat lower than in Europe. The reason for that, of course, is that in countries like Malaysia which have a quite high Moslem population, the drinking rates are reportedly relatively low. There was a small but significant minority of people who reported that their families felt that they drank too much, which suggests that there is, even in these populations, a small but significant problem with alcohol. And so there is scope for health education and promotion.

When we looked at cognitive function (the tests were not diagnostic; they can only be said to be suggestive) the figures suggest that the prevalence of dementia in these populations may not be very different from that described in Western studies.

If that finding is verified with more in-depth and more diagnostic tests, then the significance is enormous, because if you take the overall population figures, particularly for the old-old population, and look at the incidence and prevalence of dementia which may apply, and then consider what impact that will have in terms of family, community, social support needs, and so on, the result is overwhelming. This is an area where much more research is urgently needed. The interesting thing here is that while there were differences overall between the countries, the trends with aging were absolutely consistent. There was some confounding in terms of education, but even when we allowed for the impact of education (or lack of education) on performance of the cognitive function tests, the results were still significant. This is another area where there is very significant variation between the countries. But one of the interesting things is, of course, the much higher proportion of females that overall have had no formal education -- very striking, even in Malaysia.

One of the things we were a little surprised by, given the cultures we were dealing with, particularly in Fiji and the Republic of Korea, was the significant minority who reported that they felt lonely often or all of the time. This was a finding which, again in the patterns for all of the countries, the relationships seem to hold up. It clearly made a difference whether one is married or not, but little difference whether one worked or not; clearly a great difference in whether they felt they saw family and friends often enough or not. Finance and economic security had a very close relationship to loneliness. The relationship between well-being and economic circumstances was a clear one. Of course, a clear relationship between physical health and well-being in this case is reflected by loneliness. Activities in daily living, physical and mental health, seem to go hand in hand. The proportion of people reporting loneliness did not differ very much with age, just slightly. It is very similar to the findings that have been reported elsewhere in world. When compared with the 11 country study, again, it was about the same.

We looked at the relationship between various indicators of mental and physical health, comparing cognitive function, sleep problems, indications of anxiety, claims of loss of interest and so on. With performance in activities of daily living, there is a significant relationship between mental and physical performance. Again, as is fairly classically described in studies of aging elsewhere in the world, the patterns again and again seem to be consistent. Likewise, but perhaps to a less marked extent, there is a relationship between a variety of mental functions and economic circumstances. Clearly those people who felt they did not have enough money to get by had a higher rate of mental symptomatology.

There are very great variations between the countries, perhaps reflecting traditional practices as much as anything else, as well as access to, and attitudes toward, the provision of health services, in this case, illustrated by the use of medication. We found quite high rates of consumption of prescribed medication, and in some of the countries (Fiji and the Republic of Korea in particular) a very high rate of utilization of traditional medicine and traditional medical practices. In all of the countries, quite a high proportion of people were taking over-the-counter medication that was not prescribed, but was not of a traditional nature -- things like laxatives, and tonics.

By way of summary, I have presented just a glimpse of a few of the kinds of results which have now been published and are available from the World Health Organization, entitled *Aging in the Western Pacific*. As I said in the beginning, what we set out to do in this exercise was a pilot attempt at cross-cultural and comparative studies in this part of the world from which we learned a great deal. One of the things we learned was the feasibility and utility of carrying out such studies, while at the same time, learning something of the limitations of the information one obtains, and the care you have to place on interpreting the data, given the language and cultural variations.

But more than anything that struck us, wherever we looked, whether we looked at the patterns of mental illness and symptomatology, whether we looked at physical performance, whether we looked at social relationships, whether we looked at a variety of attitudinal responses to questions and age, there seemed to be a remarkable consistency in the results, in the patterns associated with aging, both between the four countries we studied, and in the main, in comparison with findings in the developed world. In a number of significant respects, the differences were as tantalizing in many ways as the similarities. It seems to me that the scope for more of this kind of cross-cultural, cross-national study is very great indeed. In our own Center, we have now extended beyond working in Asia and the Pacific to studies in the Eastern Mediterranean region of WHO. There is a survey under way in Tunisia, Egypt, Jordan, Bahrain, and Pakistan, as well as studies under way in Indonesia and Sri Lanka, and Thailand, Burma and North Korea.

Part of this work relates to research that is now being sponsored by the World Health Organization in most of the WHO regions of the world, including Latin America through PAHO (the Pan American Health Organization), and, of course, the studies that have been conducted in Europe.

The one region in the world where aging is not yet seen to be an area of priority, either in research, or in policy, or in program development, is Africa. There is beginning to be shown some interest in that region, and I think we will see increasing activity over the next decade in the African countries. In this respect, there are perhaps some very interesting things to be discovered there. One of the things that is really interesting is that it has been suggested that dementia is virtually unheard of in Africa. If that indeed turns out to be true, there is a very interesting natural epidemiological experiment.

Beyond conducting these fairly straightforward, descriptive, cross-sectional, cross-national studies, the World Health Organization, in association with the National Institute on Aging, has now established a special program for research on aging which will be one of the special programs of the World Health Organization globally. Its objectives are to achieve better understanding of the aging process through research and related activities; to search out ways to prevent age-related disorders; and to promote the interaction between older persons and society. They are broad and I think very ambitious objectives. There are four main areas of priorities that have been determined by WHO's scientific advisory committee.

- The nutritional changes associated with aging, with particular emphasis on osteoporosis.
- Age related immune function as a means of getting into the basic biological/biophysical aging process.
- Age-associated dementias, for obvious reasons, is a major area of priority.
- Determinants of healthy aging, which is perhaps the most promising area of all in terms of hopefully coming up with something that will have some utility and some impact in the future.

The plan is to sponsor, on a global basis, major studies on aging, hopefully longitudinal studies rather than straight cross sectional research, with a particular focus on identifying those factors which contribute to successful, or healthy aging, to physical and mental performance, and social integration, and to appropriate systems of formal and informal social support for the elderly that improves their well-being and physical and mental status. It is a rather better way of looking at it than to talk about the problems or disability and dependence in old age. It is looking at the same thing, but from a much more positive point of view.

ANDREWS

Why are we doing all this research on aging? There has been a tremendous explosion of various kinds of research from almost every angle that one can think of. One has to ask the question: Is this doing anything other than keeping a lot of academics and research associates in a comfortable income? I think it is time we did take a step back from the kinds of things that have been done, and examine very critically the policy and program implications and consequences that have been drawn. That is where a lot of the emphasis should go in the immediate future, not necessarily going out and collecting more and more, and more and more data, but perhaps looking at the data that are available and the data that can be collected fairly simply, and seeing how they can be applied effectively -- particularly in a language that will be significant to policy makers and planners; and to identify those areas that I think represent a priority in those respects. There is, in brief, a great deal to be learned from cross-cultural research.

CHAPTER 21

GERONTOLOGY IN HIGHER EDUCATION IN THE UNITED STATES

Thomas A. Rich

An interest in aging can be found throughout history. Issues such as the wisdom of the elders, the despair and losses of aging, the quest for immortality or how to look younger, are examples of continuing themes. However, modern gerontology begins for us sometime around the 1950s. In a few academic settings, researchers and teachers were beginning to recognize that our population was changing, primarily because of progress being made in infant mortality and that, in the 1980s and 1990s, we would begin to look more like an age concentrated society than the youthful society of the early 20th century. In addition, researchers were spurred on by a growing interest in what the process of aging involved and what older persons were really like. Unfortunately, some of the early research was conducted on captive populations of older people in institutional settings, and for a time progress was slowed because the findings seemed to reflect the very stereotypes that concerned us.

Gerontological education in the 1950s was built on self-study, on an apprenticeship to someone already in gerontology, or on taking one of the few courses offered at a university. Elizabeth Douglass (1987a), Executive Director of the Association for Gerontology in Higher Education (AGHE), noted in her summary of the background of gerontological education and training that in 1955 the Inter-University Training Program in Gerontology at the University of Michigan surveyed the country to determine the extent of aging education, and "Of 312 academic institutions responding, only 50 offered credit courses in any aspect of gerontology, and only 72 conducted gerontological research" (p. 285). The earliest formal gerontology programs were established at the University of Michigan, Duke University, the University of Chicago, and the University of Southern California. The first two degree programs were initiated in the late 60s at the University of South Florida and at North Texas State University.

So, what is gerontology? An excellent definition is provided by Robert Kastenbaum (1987) who states that:

> Contemporary gerontology includes all of the following:
> 1. Scientific studies of processes associated with aging;
> 2. Scientific studies of maturing and aged adults;
> 3. Studies from the perspective of humanities such as history, philosophy, and literature; and
> 4. Applications of knowledge for the benefit of mature and aged adults (p. 288).

It is this latter area that has experienced enormous growth from an educational point of view and is the main topic for discussion today. Robert Butler (1987) defines geriatrics as, "the study of the medical aspects of old age, and the application of knowledge related to the biological, biomedical, behavioral, and social aspects of aging to prevention, diagnosis, treatment, and care of older persons" (p. 284). While I will speak primarily about the growth of social gerontological education, there has been a corresponding interest in the development of geriatric education. The topics in social gerontology and geriatrics range from adjustment to retirement, dementia, and various health behaviors to growing issues of living alone, and of equal importance, to issues of social policy that have a major impact on the status of older adults in our society in the future.

When we talk about aging, we view it as a developmental process, or a natural consequence of the life cycle. We have refined our definitions of older adults so that we make distinctions between the young-old, the old-old, and now the old-old-old, and the central issues that may be found within these age groups. Fortunately, we no longer think of the aged as everyone from 65 to 110, which has always blurred our understanding of aging from a research and teaching perspective.

Many factors have led to the expansion of gerontological education. A major impetus for the rapid increase in the development of gerontological education and training came from the 1965 Older Americans Act which established the Administration on Aging and provided start-up funds for many universities and colleges. The program directors in the various institutions felt the need to communicate about gerontological educational issues. As a result, the Association For Gerontology In Higher Education (AGHE) was founded in 1974 "to provide an organizational network to assist faculty and administrators in developing and improving the quality of gerontology programs in institutions of higher education" (Douglass, 1987, p. 40). Today, AGHE is the major association involved in looking at growth, needs, and issues in gerontological education. To give credit to people who helped this revolution along would fill this chapter, but it is appropriate at this point to mention that the first training director of the Administration on Aging was a person who was willing to look at many approaches to gerontology and who was responsible for assisting programs in their early development. He was also behind the early formation of AGHE, and as most people in gerontology know, Clark Tibbitts was a major force behind what we call gerontological education.

Another landmark in the development of social gerontology was a monograph published in 1967, *Graduate Education in Aging within the Social Sciences.* This report was prepared by a committee of the section on psychological and social sciences of the Gerontological Society and was a major look at the definitive issues in gerontology. The committee members included Rose Kushner, Marion Bunch, Robert Kleemeier, Raymond Kuhlen, Clark Tibbitts, and Irving Webber. To provide a brief feel of what their concerns were, the following is a summary of the issues and salient problems outlined by Kushner and Webber (1967, pp. 110-112):

1. A statement of the problems, with definition of terms "gerontology" and "social gerontology", and concern with whether gerontological training programs should be in the single-discipline setting or in the co-operative framework of a multiple-discipline approach.

2. "A statement of the necessity for meeting the problems of an aging population as well as a projection of the manpower requirements for training and equipping personnel to solve the problems of the ages."

3. "A statement of the objectives of higher educational institutions in training specialists for careers in social gerontology." In other words, "how much training in the gerontological sciences and what degree of specialization in the area of research interests were needed," with much discussion at that time about the Ph.D. in gerontology.

4. "Proposals for incorporating social gerontology as an area of specialization within the established social science disciplines."

5. "Consideration of proposals for training in social gerontology as an independent discipline," seen clearly by some as the only way to approach gerontology and seen just as clearly by others both then and today as the wrong way to approach gerontology.

6. "Statement regarding the specialized training for professional services that are directed toward action programs"; recognition of the problem of getting professionals in the field geared up to understand aging and issues related to aging.

7. "Discussion of research facilities which would serve as a base for research experience such as research institutes that are university-based, government research facilities, and facilities that are privately supported."

8. "Review of the development and current status of education in the field of social gerontology methods of instruction, library materials, models, and so on."

9. "Strategies for the educational administration and support of doctoral education in social gerontology" (Kushner and Webber, p. 112), and how to conduct doctoral education, a question we are still trying to deal with.

Today, the issues of gerontological education are still with us and there are still healthy differences of opinion. For our continuing growth we need diversity and heterogeneity in our approach to gerontology.

Given this background, where is gerontological education today? How is it being taught?

1. It is taught in disciplines as a minor, a major, or is taken as a cognate, and sweeps across the board from communications, to public health, to psychology, social work, occupational therapy, law, architecture, political science, nursing, wherever it is seen that research, services or education will be related to older adults.

2. It is taught in departments as a discipline with degrees offered directly in gerontology.

From that early 1955 survey, previously cited, to a study reported by the Andrus Gerontology Center at the University of Southern California, from a study conducted and reported in 1987, 1,155 institutions were identified as currently engaged in gerontological instruction. The latest count shows that there are 14 associate level degree programs, 32 bachelor's level degree programs, 30 master's level degree program, and by latest count one doctoral program just announced as accepting students in 1989 at the University of Southern California. The University of Massachusetts now has a Doctoral program, and the University of South Florida has documents in process requesting a feasibility study for a Ph.D. in Gerontology.

Recognizing the rapid growth and expansion of all kinds of gerontological instruction, in 1986 the Association for Gerontology in Higher Education established a 27-member national Standards Task Force. The Standards drafting committee consists of 27 persons from around the country who are responsible for drafting and reviewing guidelines for gerontology programs at the associate, undergraduate, and graduate degree levels. This committee includes faculty who have been responsible for developing some of the most respected gerontology programs in the country. Other kinds of gerontological education are being studied but, here, discussion will be limited to degree programs.

First, the AA, Associate of Arts Level. These are the degree programs in community colleges and are likely to have an occupational-educational emphasis in areas such as long-term care or service delivery from an agency-based program. There are often specializations within health, public, or human services curricula.

Next, the BA, Bachelor of Arts Degree. Most of the Bachelor of Arts degree programs are described as a combination of multidisciplinary education and professional training in gerontology along with a foundation in the liberal arts model of higher educations. Some applied or practice skills are often developed through electives, specialized courses, and internships.

Next, master's degree programs in gerontology. At the master's level, the criteria for evaluation of such programs include review of the goals and objectives, the administrative structure, the type of credential, credit hours offered, and required content. The following specializations are found throughout the country:

1. *Health Organization And Planning Track.* Concentrations often tied to jobs in health care fields.

2. *Administration Track.* Often tied to public administration areas such as area agencies on aging, state units on aging, and other governmental agencies.

3. *Social Services Track.* Includes group workers, case workers, and approaches to family service agencies.

4. *Adult Education Track.* Designed for students interested in teaching careers in gerontology and in the unique needs of older persons.

5. *Psychogeriatric or Mental Health Track.* Deals with the development and knowledge of the skills in the area of mental health services for the elderly.

6. *Research Track.* Research methodology and the development of quantitative skills.

Questions are also raised about full-time/part-time faculty, training of faculty and other relevant issues that would be appropriate concerning any degree program.

The next task is to complete a set of standards so that persons from different institutions may look at what comparability exists, and to bring better understanding to the meaning of a master's degree in gerontology.

In doctoral education, recent developments, to repeat, include a Ph.D. at the University of Southern California with a specialization in social policy. There is also a program at the University of Massachusetts, Boston with a concentration in social policy. Third, a program is being proposed at the University of South Florida, also with a focus on social policy. It is interesting that independently, these three institutions decided on social policy, but that does appear to be the need on a state and national basis. Having people who possess the theoretical understanding of development and implementation of policy and the quantitative skills to either understand or gather appropriate data related to the policy making process, seems to many to be a critical need not presently being met by other disciplinary approaches.

Gerontological education has come a long way since the early 1950s. It has reached a point of acceptance and indeed enthusiasm from students who want to know more about their life cycle process and about what prospects life holds for them in the future. Many wish to understand their parents and grandparents. We still must deal with the ageisms and the stereotypes about older adults, but as each generation moves into later years, the stereotypes will have so little application that this alone may help to diminish them over time. A field that was once considered the study of nursing homes and very old people is now seen as an interesting look at one's own future and the future of the United States.

References

Butler, R.N. (1987). Geriatrics. In G.L. Maddox, R.C. Atchley, L.W. Poon, G.S. Roth, I.C. Siegler, R.M. Steinberg, & R.J. Corsini (Eds.), *The encyclopedia of aging* (p. 284). New York: Springer.

Douglass, E.B. (1987a). Association for Gerontology in Higher Education. In G.L. Maddox, R.C. Atchley, L.W. Poon, G.S. Roth, I.C. Siegler, R.M. Steinberg, & R.S. Corsini (Eds.), *The encyclopedia of aging* (pp. 40-41). New York: Springer.

Douglass, E.B. (1987b). Gerontological education and training. In G.L. Maddox, R.C. Atchley, L.W. Poon, G.S. Roth, I.C. Siegler, R.M. Steinberg, & R.S. Corsini (Eds.), *The encyclopedia of aging* (pp. 285-287). New York: Springer.

Kastenbaum, R. (1987). Gerontology. In G.L. Maddox, R.C. Atchley, L.W. Poon, G.S. Roth, I.C. Siegler, R.M. Steinberg, & R.S. Corsini (Eds.), *The encyclopedia of aging* (pp. 288-290). New York: Springer.

Kushner, R.E. & Webber, I.L. (1967). Summary. In R.E. Kushner & M.E. Bunch (Eds.), *Graduate in aging within the social sciences* (pp. 110-113). Ann Arbor: Division of Gerontology, University of Michigan.

CHAPTER 22

A THEORETICAL OVERVIEW OF AGEISM IN THE UNITED STATES: CRITICISMS AND PROPOSALS TOWARD A NEW OUTLOOK

Lee-jan Jan and Anne Thacker

Today, there are approximately 30 million people age 65 and over in the United States, and the number is growing (Szulc, 1988). In just three decades this number will almost double to 57.4 million, representing 20% of the projected population for that year (U.S. Bureau of the Census, 1984). This dramatic growth in the population of the elderly affects the overall population composition drastically.

Ignoring these realities, people in society generally have a negative attitude toward such a significant section of the population. The consequences of this negative stereotype are twofold: 1) at the personal level, most older persons are viewed as helpless, dependent, poor, lonely, and incompetent. This view affects the way people in general interact with older persons, making the interaction mostly unpleasant for both parties and, in some cases, avoiding interaction with older persons altogether. Worse yet is the effect of this stereotype on the older person's self concept, causing her/him to assume the incompetent role as a self-fulfilling prophecy (Brigham, 1986; Julian and Kornblum, 1983; Levin & Levin, 1980); 2) society's view of the elderly is so negative, many people seem to feel that it would be best to exclude older persons from active participation in mainstream social activities. Thus, older persons fall victims to discrimination, prejudice, and unfair social policies (Atchley, 1988; Austin, 1985; Levin & Levin, 1980; Powell, 1980). These practices cause grave injustices to the aged and result in great losses to the society.

Several theories have been postulated as possible explanations for how the elderly have come to be placed in an inferior position in

American society. One of the most widely discussed of these is *modernization* (Cowgill & Homes, 1972; Cowgill, 1974). Since the beginning of modern industrialization, the status of the aged has begun to decline. This theory explains that the onset of this change occurred with the shift from an agricultural to an industrial society. In agricultural societies, older persons are viewed as keepers of tradition or wisdom and values, and generally have effective control over distribution of property, food production, and religious rituals and institutions. As such, they are highly regarded and respected. Yet with a shift toward an industrial society the aged lose control over these things, and thereby lose respect (Atchley, 1988; Levin & Levin, 1980 Palmore, 1980). Urbanization and high mobility led to the trend of nuclear families which separates the younger generation from the elderly, stripping them of traditionally respected leadership roles. Meanwhile, with the increase in education, younger members of society rely less on older persons as a source of knowledge. Levin & Levin (1980) suggest that because the younger people are increasingly better educated, the older people are in a disadvantaged position to compete for jobs, status, and power. Forced retirement further reduces the standard of living and social status of the aged since social status is generally related to work roles and economic position.

The major problem with this theory is that it incorrectly focuses on age as the main factor in the older person's inability to keep up with a modern, technological society. Yet, the factors that affect an individual's status in society are primarily economic resources and knowledge, not age per se (see attribution theory later). In a modern technological society, anyone, regardless of age, who lacks economic resources and knowledge is going to suffer an inferior status. Although age may be correlated with lack of economic resources and knowledge age, per se, is not the explanation for the elderly's inferior situation.

Also, modernization does not necessarily lead to the decline of the status of the elderly. For example, in Japan, a highly industrialized society, respect for the elderly still remains high (Eshleman et. al., 1988). The cultural and social factors that maintain older Japanese's social position should be identified and studied more thoroughly.

Attribution theory tries to explain the plight of the elderly as stemming from a fundamental attribution error; that is, people tend to attribute the cause of behavior and its consequences to the dispositional characteristics of a person rather than to environmental factors. In this case, it is the older person's age that has been seen as the cause of his/her situation. Whatever has happened to the elderly, people see the reasons as "because they are old" and ignore the environmental factors. Therefore the elderly are being blamed, not the society. Since age is a permanent trait that cannot be changed, and is generally seen as getting worse as years go by, there is little wonder that society is indifferent about the elderly's situation.

Both Palmore (1980) & Levin (1980) have agreed that the *minority group* theory can be applied to the elderly because in this youth-oriented society the elderly have been treated in many ways as other minority groups and have been given such a status. For example, because of their age, older persons suffer discrimination in areas such as employment and obtaining credit, which results in deprivation in terms of income, education, and general social prestige. Although Palmore (1980) feels that older persons are ashamed of their age and are unwilling to identify themselves as aged, most elders have shown little evidence of organizing or developing a self-consciousness as a group as have many other minority groups. However, he sees some signs that this may be changing, particularly in the fact that older people are identifying with other older people and older people's organizations which work to overcome age-related discrimination. From the conflict perspective, this is precisely the beneficial function of viewing elderly people as a minority group; that is, identification with other elderly would lead to organization and political action toward eliminating injustices.

Streib (1965) examined the definitions of minority groups and found that although the elderly do suffer some injustices in society, viewing the aged as a minority group does not clarify their social status in our society. For example, old age is part of the life cycle as is young age; therefore, if the aged were viewed as a minority group, so should the young. Furthermore, there is a lack of intra-group identity and a lack of a sense of consciousness-of-kind among older persons. The aged are not excluded from being elite and influential members of the society, and their civil rights are not drastically curtailed. True, many of the aged, like many minority group members, are underprivileged -- this is the principle reason for the incorrect minority group analogy. But it should be noticed that those older persons who are economically deprived probably have been underprivileged throughout their lives. Although age as a status characteristic compounds multiple deprivations for many groups, including minority groups, it is inappropriate to equate a 'deprived group' to a 'minority group'.

In addition to Streib's criticism, there are further problems in applying the minority concept to the elderly as a group. Minority group theory has two main problems. The first is the fact that the elderly are not born into a minority group, like other minority groups. The second is that eventually everyone will be a member. These distinctions make it important not to view the elderly just as another minority group. For other minority group members, the socialization into the minority role starts at the beginning of life; yet, for the elderly, it is resocialization to adjust to their new role. Therefore, it is much harder for an older person to accept this role, and it is actually to the older person's advantage not to accept such a negative role easily. Second, the role of the elderly in the society is still in the process of formation. Although negative stereotypes exist, the elderly have more room left to create positive images. This should be considered an advantage when compared with other minority groups who have to change long established negative stereotypes and roles. Third, inevitably, everyone will end up in this group. When the middle aged members of the society realize that they soon will be members of this group themselves, they may initiate positive changes through legislation that will benefit themselves in the future. Therefore, to explain the elderly's situation as a minority group is not only inaccurate, but also may do a disservice to the elderly.

Cumming and Henry (1961) coined the term disengagement to describe the process by which many of the relationships between elderly persons and other members of society are severed and those which remain are altered in quality. Disengagement has been viewed as a natural and mutually beneficial process for both society and the individual (Atchley 1988, Brigham 1986, Levin & Levin 1980). Societal disengagement is a process whereby society withdraws from the individual or no longer seeks the individual's effort or involvement. Thus the positions can be vacated and filled by more energetic and aggressive younger members. This is assumed to be good for the society as a whole. On the other hand, individual disengagement has been viewed as primarily a psychological process involving withdrawal of interest and commitment on the part of an older person. This frees the older person from the pressure of work and competition, thus allowing him/her to live a more leisurely and enjoyable life. Therefore, the theory is that disengagement is also good for the elderly. Some older persons may be just complying with what they perceive as the wishes of society for them to withdraw or may disengage because they see society as devaluing them. Disengagement theory views most elderly persons as voluntarily disengaging themselves from the society. It has been argued that this theory made a contribution by presenting the view that old age is a normal stage of life, while a lower level of social involvement and activity can still be highly rewarding (Eshleman et. al, 1988).

The problem with this theory is that it takes a functional perspective and suggests disengagement is good for both the society and the individual. However, it ignores the dysfunction that disengagement can cause those elderly persons who are unwilling to disengage. These include the loss of prestige, the loss of identity or even the loss of their livelihood, or simply the loss of alternatives to achieve life satisfaction. Disengagement can also cause society to lose valuable human resources, not to mention increasing the burden on society since the proportion of the aged is ever increasing.

Activity theory argues that older people want to maintain high levels of activity. The theory suggests that there is a positive relationship between activity and life-satisfaction and that the greater the role loss the lower the life-satisfaction (Havighurst et. al., 1968; Lemon et. al., 1977; Levin & Levin, 1980; Neugarten, 1977). Therefore, inactivity is detrimental to the elderly when they are out of the mainstream of society and its activities. However, in this theory, inactive older persons are implicitly criticized for their inactivity and thus are blamed for their resulting decline.

The main flaw in activity theory is that it has always focused on the consequences of inactivity rather than including possible explanations for this inactivity. In order for older persons to remain active they must first be given the opportunity. Atchley (1988) feels that substitutions for lost activities are not readily available. Retired people often cannot find new jobs; widows cannot find new mates. Also, the idea of substitution itself is a disadvantage to the elderly if activities are lost through loss of income or physical decline. Even though substitution may be a feasible and attractive way to cope with loss early in life, with age it becomes increasingly more difficult to put into practice. It is at this point that the self-fulfilling prophecy takes its toll on the elderly. Unfortunately, some elderly tend to rely on the image that society imposes on them. Julian & Kornblum (1983) feel that the elderly internalize this image and, eventually, their own self-image and behavior correspond to the weak, incompetent, useless image that has been forced upon them. Thus, they remain inactive.

Another point is that life satisfaction is not positively related to just any activity, as Lemon et al. (1977) discovered. Informal activity such as interaction with friends, relatives and neighbors was significantly related to life satisfaction whereas solitary activities such as housework, and formal activities such as involvement in voluntary organizations, were not. Future studies should further delineate more specifically the types of activities that enhance older persons' life satisfaction.

Based on exchange theory, Dowd (1975) saw the real cause for elderly persons' disengagement and inactivity as a loss of bargaining power in an exchange relationship with society. In an industrialized society people who control economic resources and/or have special skills command more bargaining power, gaining higher status in the exchange relationship. Yet, because of their weakened bargaining power due to their limited ability to attain new skills, more resources, and better health, older persons accept the inferior status and what society had to offer them.

But as Streib (1983) pointed out, exchange theory is essentially a micro-level theory of interpersonal and small group interaction. Therefore, to meaningfully analyze the relationships between elderly people and the society by use of exchange theory is difficult because this relationship is at a macro-level and too vague to be studied by empirical means. Furthermore, in response to Dowd's notion that older people in industrialized society have fewer power resources to exchange in daily social interactions, Streib feels that, as a result of lifetime social interactions and experiences, elderly people build up a cache of power credits which extends far beyond Dowd's focus only on present power resources.

Atchley's (1976) theory of adjustment points out that it is important conceptually to view retirement as a process which happens with a sequence of phases -- 'honeymoon', 'disenchantment', 'reorientation', 'stability', and 'termination'. These phases refer to the different states retirees usually go through and should be helpful to research in describing and understanding post-retirement attitudes and behavior more accurately than research which lumps all post-retirement attitudes and behavior into a single category. The mechanism of adjustment involves two central processes: 1) internal compromise which involves assigning priorities to roles in the hierarchy of goals. For example the importance of a job in an individual's hierarchy of goals would certainly have great impact on one's retirement; and 2) interpersonal negotiations; because human beings are social animals, the adjustment usually involves interactions with significant others in developing and stabilizing the hierarchy of goals. However, Streib (1983) feels that even though the emphasis on hierarchy of social goals is useful in studying people with higher status occupations, it might be too pretentious for many ordinary people whose goals are merely to 'manage' or to 'get by'.

In addition to the unique problems each theory has, they also share some common problems. First, most of the theories, except attribution theory, take a victim-blaming approach. Because elderly persons lose bargaining power, cannot keep up with technological change in industrial society, cannot find suitable substitutions for lost activities, cannot take a minority status, or cannot disengage themselves willingly from the society, they cause their own problems. The main problem, here, is that victim-blaming does not examine the role of social structure in creating the conditions under which the aged must exist (Levin & Levin, 1980). Therefore the burden of improving the situation rests with the elderly, not the society.

Second, although all the theories make suggestions for changing the situation, with the exception of disengagement theory, their outlooks for the aged tend to be pessimistic because age is a permanent characteristic that cannot be changed and because the elderly are already in a less powerful and less resourceful position to make changes. Changes initiated by the society are usually seen as stemming from the kindness or generosity of the society, often ending up as a form of charity or public assistance which is not only hard for the elderly to accept but further degrades their position.

Third, all of the theories take for granted that the stereotypes society holds toward elderly people are true. However, empirical data indicate there are a lot of discrepancies between the stereotype and the reality. For example, studies in both the United States and Great Britain indicate that older persons have a high degree of social contact with their children and other relatives (Streib & Thompson, 1960; Townsend, 1957). Therefore, to try to explain elderly people's situation as a group according to the stereotype is incorrect. Another problem is that because the stereotype is viewed as true, there is a lack of examination of how this stereotype has developed, along with the failure to realize the impact of this stereotype on older people.

To further the understanding of the inferior position of some elderly people, rather than focusing solely on social roles and economic resources as presented in the theories, a new direction should be taken -- the development of negative stereotypes should be examined. The following may be contributing factors to the development of negative stereotypes which deserve more research and close examination.

The effect of social distance, as found in much of the literature, plays possibly the most important role in the development of a negative attitude toward the elderly. In an industrial society, the nuclear family becomes the modal type. Older members of society are expected to live apart in independent households or to seek institutional care (Levin and Levin, 1980; Palmore, 1980). The aged are segregated from other age groups, resulting in the aged being viewed by the rest of the society as an out-group. When there is a lack of contact, people tend to rely on stereotypes, resulting in many misconceptions of the elderly along with exaggerated misconceptions of the differences between the aged and all age groups. For example, Borges and Dutton (1976) have found that as a person grows older, he perceives the years ahead more optimistically. In their studies, older subjects rated their lives as better than younger subjects projected their lives would be at the same age. Their data reveal that there was a significant lack of awareness in younger people of the potential satisfaction in the middle and latter years. Younger people think that getting old is worse than it apparently is. To avoid facing the unpleasant potential future and their vulnerability to it, young people further reduce contact with the elderly, thereby increasing the social distance. Thus a vicious circle is set in motion. Borges and Dutton (1976) feel that closer contact between the generations might reduce the discrepancy in judging life satisfaction between younger and older groups. Palmore's (1977, 1980) Facts on Aging studies have identified many misconceptions concerning the aged. For example, as one of the most frequent misconceptions, Palmore found that 74% of those surveyed thought that the majority of the aged are frequently bored. Palmore's list of correct facts obtained first hand from the elderly themselves indicate: 1) only 17% of persons 65 or over say that "not enough to do to keep them busy" is a "somewhat serious" or "very serious" problem; 2) two-thirds of the aged say they are never bored or hardly ever bored; and 3) 87% of those 65 or older say they were never bored in the past week.

The portrayal of the elderly in the mass media plays a big part in people's views toward the elderly (this will be further discussed later), particularly when portraying them as frequently bored. Numerous television commercials have portrayed the elderly as having nothing else to do than to sit on their porches and drink lemonade while waiting for the weekend when the family comes to visit. It is this misinformation people receive not only through the mass media but also from other informants, rather than talking directly with the elderly, that lead them to believe in the stereotypes. Thus, increased proximity may break down some of the stereotypes that younger people hold against the elderly (Atchley, 1988; Borges & Dutton, 1976; Luscz & Fitzgerald, 1986).

The socialization process has allowed great room for the development of many unconscious attitudes. People have been socialized into identifying certain age groups with certain social classes, thus developing a picture of each class in their minds. Middle-aged people are usually associated with the middle class and elderly people are usually associated with the lower class. When people picture the middle class, they tend to have positive feelings. Yet, when people picture the elderly, they tend not to have the same middle class related positive views, but instead, have a negative lower class related image in their minds. Thus, there is a misconception in viewing the relationship between age group and social class. Unfortunately, even the elderly are socialized into accepting certain roles. Brigham (1986) suggests that older persons absorb myths from the general culture. Julian and Kornblum (1983) suggest that older persons tend to rely on the image that is imposed on them. They internalize it and, eventually, their self image and behavior correspond to the weak, incompetent, useless image that has been forced upon them.

Education may be a powerful mediator for this situation. Palmore (1980) found in his studies that less educated groups have substantially more misconceptions about aging than more educated groups.

The mass media have been viewed as the major legitimizer of control of the aged (Powell, 1985). Powell feels that television, radio, newspapers and magazines, due to their role in defining and redefining social reality, are the chief disseminators of ageist stereotypes in American culture. Negative stereotyping of older persons by the media serves to justify the process of denying the elderly access to societal resources like status, power, wealth and decision making authority. Negative stereotypes contribute to low self-esteem and a sense of powerlessness and helplessness in older persons.

Usually, older persons are given two alternatives in the mass media. When they are included they are given negative roles. Otherwise, they are omitted totally from many of the mass media, resulting in further negative roles. Powell (1985) explains that the omission of the elderly in commercial advertisements has two major implications. First, omission implies a lack of value in that the elderly are viewed as no longer sufficiently important to American society to be used as positive role models in advertisements. Second, omission implies exclusion from active participation in the mainstream of American social life by suggesting that the elderly's opinions and demands are of no real consequence and can therefore safely be ignored. Hess (1974) suggested that in the absence of high levels of interpersonal contact, the burden of information dissemination falls upon the media. In today's society, other age groups rely upon the mass media for information concerning the elderly more than ever before. Hess urged the mass media to present information, role models, and positive images of all age groups. Yet, it has been more than a decade since Hess reported, and older persons are still being given negative roles or are not being included in many forms of mass media.

Hess further explains the phenomenon of "pluralistic ignorance," which involves individual members of a group assuming that they are virtually alone in suffering the social attitudes and expectations they do, unknowing that others privately share them. This pluralistic ignorance, complemented by the process of the self-fulfilling prophecy, may be the reason that some old people have come to behave in a stereotyped manner. However, there is some indication that elderly persons are beginning to realize and overcome this "pluralistic ignorance" by organizing themselves into age-related groups such as the AARP (American Association of Retired Persons), Gray Panthers, and Councils on Aging.

Robertson (1980) stressed that ageism has deeply pervaded American life and discrimination against the aged can never be effectively eliminated until the stereotypes on which it is based are abandoned. This can only be achieved through a joint effort of both older persons and the rest of society. Only when there is a widespread individual awareness and a widespread social awareness of the problem of the aged will any significant changes be made. Based on the theories and research discussed, some suggestions can be made.

One of the first steps the elderly can take is to develop continuity as a central means for adapting to and coping with many of the changes associated with aging. This adaptive strategy, according to Atchley (1988), involves continuity of activities, relationships, independence and self-esteem. Yet, at the same time, society must play an important role in first offering social relationships and support.

A second step for the elderly to take is to accept themselves as aging people and to emphasize their maintained competence. According to Brigham (1986), many elderly persons have already begun to enhance their feelings of power and control and are therefore less prone to feelings of learned helplessness. He also states that many elderly persons have been refocusing self-attributions of competence by reattributing their negative feelings to environmental forces, as opposed to attributing their failures to themselves, in order to achieve significant improvements in self-esteem. Increasing feelings of competence and overcoming negative stereotypes are other ways for the elderly to maintain independence and self-esteem.

A third step for the elderly is to not only be involved in organizations they have already formed but to continue to form other organizations and remain active. These older Americans need to realize that they are coming to represent a larger portion of the population. Furthermore, they need to realize that they are a valuable commodity who used to be valued for their rarity and presumed quality. Yet, today they are gaining value as both a political threat and an economic resource on the basis of relative quantity (Powell, 1985).

The most important and basic step for society is to break down the negative stereotypes and build a healthy understanding and an accurate perception of the aged. This is difficult, as Hess (1974) stated: "We are unlikely to want to find out more about what we refuse to even think of." But people in American society must realize, no matter how much we dread doing so, that everyone will want to maintain activity, self-reliance, freedom, and dignity rather than being closed in nursing homes where we lose our identity, self-esteem, and autonomy. If a basic healthy understanding and accurate perception are acquired by society, then the other things will fall into their places naturally. In order for society to have correct information to formulate positive attitudes toward the elderly, more research concerning all aspects of the elderly and dissemination of this information is needed. Along with this is the need for more research on the misconceptions other age groups hold about the elderly. Palmore's Facts on Aging quizzes should continue to be distributed to all age groups because they are not only useful in identifying misconceptions concerning the aged, but also serve as a good tool to sensitize people to their misconceptions and stimulate discussion. As Palmore (1981) pointed out in his conclusion, even the more highly educated people are "amazed" about the facts they missed.

Once there is a social awareness of the correct facts, the society should realize that older persons are not only a strong political force that needs to be recognized (there are signs that society is already beginning to notice that), but also a major economic force because of the purchasing power of older persons. With this realization, the mass media should be able and willing to portray more positive roles for the elderly, especially in commercial advertising which is mostly restricted to some stereotypical health problems. In turn, this may further change society's views of older persons to more accurate ones.

Atchley (1988) feels that more often than not our cultural beliefs about the causes and consequences of aging have turned out to be either substantially incorrect or at least misleading. One of the reasons for these misconceptions is the lack of communication between the elderly and other age groups. It follows then that people must depend on other means of obtaining information in this area, for example, mass media, rather than first hand statements from the elderly. Thus, social distance plays a big role in the development of misconceptions, and *furthers* the social distance. With the misconceptions clarified, the social distance between the aged and other age groups can be more easily reduced and interpersonal contact between the elderly and the young increased. This should make it easier for the elderly to be reintegrated into the mainstream of society.

At the same time, social policymaking should be based on research results, integration of the elderly should be encouraged, and a means should be provided to enhance older persons' economic opportunity, social status and general autonomy. Examples include elimination of the mandatory retirement age, affirmative action protection from job discrimination, subsidies for families who keep their elderly members at home, and integrated housing. Some of these policies are already being adopted, but slowly.

Recent research has indicated a positive shift in attitudes toward the elderly (Austin, 1985; Brigham, 1986; Borges & Dutton, 1976; Hess 1974; Fitzgerald & Luscz, 1986). Tibbitts (1979) suggests that older people have improved self-attitudes that potentially influence the views others hold toward them. Austin (1985) follows Tibbitts' views by saying that since older people have assumed more productive roles in recent years, such as being members of the United

States Senate and President, others have been led to develop more positive attitudes toward the elderly, which has resulted in higher preference for old age in the hierarchy. Further evidence can be seen in television documentaries, especially those commentaries concerning social issues. ABC's 20/20 recently broadcast a program covering the problems of age discrimination in the work force. Also, elderly persons have been given the leading roles in television commercials such as McDonald's restaurants and sportscar advertisements. This is especially noteworthy because these businesses were previously almost exclusively youth-oriented.

This chapter has examined the theories associated with ageism, has made suggestions for future research, and has also provided some suggestions for a cooperative effort between older persons and the society as a whole to improve the current situation of elderly people. Although there are signs that attitudes toward older persons are shifting in a more positive direction, the problems these older people are facing in this society, as discussed in this chapter, would make one question what the future holds for elderly people.

A THEORETICAL OVERVIEW OF AGEISM IN THE UNITED STATES: CRITICISMS AND PROPOSALS TOWARD A NEW OUTLOOK

Addendum*

Based on the observation of the Pensacola Conference and the issues mentioned in our paper, a few points warrant further emphasis:

It is especially alarming that the presenters in the conference kept referring to the aged population as a "concern", or a "problem", for two reasons: 1) The presenters are specialists in gerontology; their unconscious adaptation of the stereotype serves as an indication of how pervasive the stereotype is in the society; 2) As we all know, reality is socially constructed and the researchers in this area are powerful agents in constructing this reality for both the elderly people and society. This unconscious negative attitude is going to bias their research and the research findings may help to construct a reality that may not serve a good purpose for either the elderly or the society.

The papers presented were mostly demographic studies with statistical information which provided good descriptions but did not provide adequate explanations for the phenomena they described. One reason may be that these studies did not have a theoretical foundation. Another reason may be due to the fact that the studies' inability to offer explanation is an inherent weakness of quantitative and correlational studies. Thus, not only should theories be employed in future studies, but a qualitative approach also needs to be adopted in studies in this area to offer insight and understanding.

One of the principal emphases was cross-cultural comparative research; indeed there were studies involving data collected from several different societies. But the problem is that even though differences and discrepancies in elderly people's economic, health, and general status are identified among the different societies, the researchers did not try to identify the potential unique social and cultural factors that may have caused the differences. Thus the we are left with a lot of facts but no explanations. This not only fails to further understanding but also does not help in planned social change, if some situations are deemed to be in need of alleviation.

For future planning purposes, many projected the number of older persons who may be in need of some form of support at certain distant futures. The projections are based on today's age classifications, and health and economic status. This kind of projection may be rendered invalid by medical improvements, and social and economic changes, for example, the elimination of mandatory retirement age. Therefore, when the future time arrives, the projected elderly population may be so different from the elderly people of the same age today that the descriptions and criteria based on today's elderly population may not be useful anymore. Also, due to better health and a possible longer, productive life, the predicted dependent population may be much smaller than was estimated.

Some participants also suggested that studies which try to gauge future elderly people's needs and interests by surveying elderly people today may not have much validity. As stated above, the future elderly will be different. Therefore, it may be more valid to survey middle-aged people to see what their future interests or preferences may be.

In conclusion, a new and more dynamic means of conceptualizing aging and the elderly needs to be developed. This should include theory and methods free from bias, more realistic examination and explanation of aging issues, and practical information for future planning.

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References

Atchley, R.C. (1988). *Social forces of aging*. California: Wadsworth.

Austin, D.R. (1985). Attitudes toward old age: A hierarchical study. *The Gerontologist*, *25*, 431-434.

Borges, M.A. & Dutton, L.J. (1976). Attitudes toward aging: Increasing optimism found with age. *The Gerontologist*, *16*, 220-224.

Braithwaite, V.A. (1986) Old age stereotypes: Reconciling contradictions. *Journal of Gerontology*, *41*, 353-360.

Brigham, J.C. (1986). *Social psychology*. Boston: Little Brown & Company.

Cowgill, D. (1974). Aging an Modernization: A revision of the theory. In J. Gubrium (ed.), *Late life communities and environmental policy*. Springfield, Ill.: Charles C. Thomas.

Cowgill, D. & Holmes, L. (1972). *Aging and modernization*.. New York: Appleton-Century-Crofts.

Cumming, E. & Henry, W. (1961). *Growing Old*. New York: Basic Books.

Dowd, J. (1975). Aging as exchange: A preface to theory. *Journal of Gerontology, 30.*

Eshleman, J.R., Cashion, B.G & Basirico, L.A. (1988). *Sociology: An introduction*, Third Edition. Glenview, Ill.: Scott, Foresman and Company, 325-353.

Havinghurst, R.J. & Neugarten, B.L., & Tobin, S.S. (1968). Disengagement and patterns of aging. In B.L. Neugarten, (Ed.), *Middle age and aging: A reader in social psychology.* Chicago: University of Chicago Press, 262-172.

Hess, B.B. (1974). Stereotypes of the aged. *Journal of cmmunication, 24,* Autumn.

Julian, J. & Kornblum, W. (1983). *Social problems.* New Jersey, Prentice-Hall, Inc.,

Lemon, B.L., Bengston, V.L. & Peterson, J.A. (1977). An exploration of activity theory of aging: Activity types and lifes satisfaction among in-movers to a retirement community. *Journal of Gerontology, 27.*

Levin, J. Levin, W.C. (1980). Ageism: Prejudice and discrimination against the elderly. California: Wadsworth Publishing Company.

Luscz, M.A. & Fitzgerald, K.M. (1986). Understanding cohort differences in cross-generational, self, and peer perceptions. *Journal of Gerontology, 41,* 234-240.

Neugarten, B.L. (1977). Personality and aging, In James E. Birren and K. Warren Schaie, (Eds.), *The handbook of the psychology of aging.* New York: Van Nostand Reinhold.

Palmore, E. (1977). Facts on aging: A short quiz. *The Gerontologist, 17,* 315-320.

Palmore, E. (1980). The facts on aging quiz: A review of findings. *The Gerontologist, 20*, 669-672.

Palmore, E. (1981). The facts on aging quiz: Part two. *The Gerontologist,* 21, 431-437.

Powell, L.A. (1985). Mass media as legitimizers of control. In Williamson, John B.; Shinduhl, Judith A.; and Evans, Linda, *Among public policy: Social control or social justice?* Illinois: Charles C. Thomas.

Robertson, I. (1980). *Social problems*. New York: Random House.

Sculz, T. (1988). How We Can Help Ourselves Age With Dignity. *Parade Magazine*.

Streib, G. (1983). The social psychology of retirement: Theoretical perspectives and research priorities In J.E. Birren et al. (Eds.), *Aging: A Challenge to Science and Society*. Oxford: Oxford University Press.

Streib, G. & Thompson, W.E. (1960). The older person in a family contact. In Clark Tibbitts (Ed.), *Handbook of Social Gerontology*. Chicago: The University of Chicago Press.

Tibbitts, C. (1979). Can we invalidate negative stereotypes of aging? *The Gerontologist, 19*, 10-20.

Townsend, P. (1957). *The family life of old people*. Glencoe: The Free Press.

U.S. Bureau of the Census, Statistical Abstract of the U.S.: 1988 (108th Edition) Washington, D.C., 1987.

CHAPTER 23

DIRECT CARE PERSONNEL SHORTAGES IN LONG TERM CARE: GLOBAL IMPLICATIONS

Marie E. Cowart

The issue of personnel requirements in long term care has received much attention recently as widespread shortages of personnel in health and long term care facilities have assumed crisis proportions in countries like the U.S. and Great Britain. Although such shortages have been cyclical in the past, the current shortage will last well into the next decade.[1,2] The U.S. health and long term care personnel experience has relevance for other capitalistic and newly industrialized nations such as Hong Kong and Taiwan. The problem we face is that of equalizing the supply and demand for personnel in health and long term care facilities in the U.S. In addition, employment in long term care must be made more satisfying and attractive for nurses and nursing assistants in order to meet the needs of a rapidly growing older population.

Assumptions. The health care industry in Florida is a rapidly changing environment about which we can make some assumptions. As industries go, health and long term care institutional services are labor intensive, requiring large numbers of personnel around the clock, seven days a week. Today, patients or clients in institutional settings like acute hospitals and nursing homes are sicker, have shorter lengths of stay, and undergo more technical procedures and treatments at a higher than ever cost in an increasingly competitive business atmosphere. The proportion of Florida's population who are elderly, especially the over 85 year old age group, who require more services than younger persons, is growing at a rate that has surpassed the rate of increase for other states.

The need for health and long term care personnel is driven by the demand for services, which can be measured by occupancy rates for hospitals and nursing homes. The state's almost 500 nursing homes have an occupancy rate of well over 90 percent while the 270 acute care hospitals have declined in occupancy from 69.7 percent in 1980 to 56.6 percent in 1985.[3] In Florida hospitals, these rates are even more pronounced because of the seasonality of tourism and part-time residents. Some hospitals experience capacity occupancies in January and as low as 25 percent occupancy in July. Long term care facilities are not as affected by seasonal occupancy fluctuations. The fluctuations in demand for hospital services and the regular high demand for nursing home services make staffing of long term care facilities a complex task, particularly in Florida where the availability of personnel is seasonal following the annual tourism patterns.

Definitions

In discussing personnel requirements some pertinent definitions are helpful. The hospital and nursing home industry defines shortage according to the number of budgeted, unfilled full-time equivalent (FTE) positions for a discipline or category of worker. Measurement of shortage is by vacancy rate -- the ratio of unfilled FTE positions to the total number of budgeted FTE positions for the discipline in a unit of interest such as a hospital or nursing home. Unfortunately, vacancy shortage measures only one kind of personnel problem and ignores others related to deficient scheduling, inadequacy of position mix and staff turnover. Vacancy is a dubious measure because the number of established budgeted positions are normally not based on staffing need, but rather, individual administrators' standards set for individual institutions according to budget priorities at the time. Thus, the number of budgeted nursing positions vary by time and individual pressures and philosophies.[4] Basing personnel requirements on patient and client needs would provide a sounder basis for determining staffing requirements. If this were the case, then vacancy rates would be a more valuable indicator of personnel adequacy.

Since nurses make up by far the largest group of workers in acute and long term care, this paper will focus on registered nurses with some mention of nursing assistants. In the U.S., the largest category of direct care providers, nurses, has documented personnel shortages back to the 1920's, when shortages were in evidence despite the return of discharged army nurses to the civilian workforce. Again, during World War II, personnel shortages on the homefront due to nurses enlisting in the armed services led to the establishment of the Cadet Nurse Corps, a shortened educational program designed to assure an adequate supply of nurses. Again, after the war, an expansion of hospital beds led to a postwar nurse shortage.[5] In 1979-81 another widespread shortage stimulated increased nurse salaries. Soon to follow was a surplus of nurses during which Florida hospitals downsized by laying off 5 percent of employees and switching to part-time personnel. This occurred as hospitals made preparations for changes in reimbursement in Medicare -- from cost-plus retrospective reimbursement to a fixed-priced prospective payment system by Diagnostic Related Groups.[6] Just a few years later, the U.S. was again faced with a new personnel crisis.

At this point, the focus of this chapter will be to examine the characteristics of this shortage from both supply and demand perspectives.

Supply Characteristics

In 1987 there were 75,000 registered nurses in Florida and 80 percent of these were in the active workforce. Of working nurses, 66 percent worked in acute hospitals, 5.5 percent in nursing homes and 6.1 percent in home health agencies. The supply increased by 55 percent from 1977-1984.[7]

Significantly, concurrent with this shortage were fewer enrollments in schools of nursing. Reports of the Florida Board of Nursing indicated that admission rates in schools of nursing declined by 43 percent from 1983 to 1987, statewide.[8]

In the same time period, the UCLA annual survey of college freshmen (1987) revealed that students preferred fields where financial remuneration would be greatest, and there was less interest in people-oriented fields like social work, allied health, ministry, the humanities and teaching. Women, who formerly selected teaching and nursing, were selecting law, medicine, computer science, and engineering.[9] Enrollments in social work respiratory therapy, and radiology also declined.[10] These factors provided prospects for a long term personnel shortage.

Demand Characteristics

When we look at the demand side, changes in the health system affected the increased demand for health personnel. As the system grew in complexity, a greater diversity of positions or job options became available in health care. Many developed beyond the shift work of the hospital and nursing home in settings like home care and ambulatory surgery centers. The increasing corporatization of health care led to greater use of part-time personnel in order to provide greater staffing flexibility, efficiency and economy in labor costs. Temporary staffing agencies that provided "Kelly Girl" nurses proliferated.

Greater demand for better prepared categories of personnel was supported by American Hospital Association data, which showed higher vacancy rates for registered nurses than licensed practical nurses or aides/orderlies in 1981. Maldistribution of personnel also existed, as evidenced by higher vacancy rates in small, southern, and investor owned institutions. Overall rates doubled from 1986 to 1987 from 6 percent to 13 percent.[11] During times of surplus, salaries flatten, but in shortage periods there are greater salary and fringe benefit increases. There were also wide ranges in salaries from urban areas like Miami to the rural Florida Panhandle areas. There were also wide differences in salary by place of employment, with nurses in Florida hospitals making an average of $25,000 in 1987 and $21,000 when employed in nursing homes. Home health salaries fell between at $23,000.[12] Two points are made here. Considering that the average nurse has 15 years work experience, these salaries are relatively low, with minor financial advancement or salary compression over the career. Considering the needs for recruitment of labor for long term care, the lowest paid positions in nursing homes served to recruit poorly qualified staff for long term care of the elderly. Lower paid staff also resulted in more vacancies and greater staff turnover in nursing homes.

International Picture

Interestingly, both supply and demand trends follow similar patterns in Anglophone nations, particularly Britain. In England in the mid-80's there were pressures to reduce costs and improve efficiency resulting in reduced overlap in staffing shifts. Recently, there was a wide spread shortage of personnel in Britain due to shortened hours, more community based job opportunities and increased patient sickness levels. At the same time, declines in enrollments in nursing schools of up to 25 percent make future shortages certain in Great Britain.[13]

Effects on Long Term Care

These supply and demand characteristics are exaggerated among long term care personnel where there are low proportions of professional and technical workers and high proportions of service workers. Nursing homes are staffed with professional nurses, but by far the largest category of personnel is nursing assistants. These employees have short or no initial education or on-the-job training. Their wages are at near minimum wage, and there are limited career ladder opportunities, high turnover, and task orientation rather than client-need orientation in the workplace. Working "short-handed" over time leads to staff burnout, fatigue, absenteeism, and strain among the co-workers. The impact on patients and clients results in delayed treatments or medicines, and less time to help with independent functions, which increases dependency among clients. There is less continuity and attention to individual preferences when staffing is shored up with parttime personnel, especially nurses from temporary staffing agencies. The Federal Bureau of Labor Statistics studies of homemakers aides, long term care social workers and workers in federal Administration on Aging programs like Meals on Wheels (1975, 1979, 1980) identify the weaknesses just mentioned in the long term care job market.[14] They point out that social workers who hold long term care jobs varying from casework, group work, supervision, and planning also earn less, have fewer career ladder opportunities and less job security than social workers in other settings. Generally, in Administration on Aging funded programs there is low salary, high turnover, few promotion opportunities, geographic maldistribution, and poor fringe benefits (pension plans and health insurance) in voluntary not-for-profit senior services agencies. These characteristics of the long term care labor force hold today. In January, 1988, the Florida Health Care Association and Florida Association of Homes for the Aged reported that 94 percent of nursing homes and hospitals in their convenience sample (n=261) had inadequate staffing. Vacancy rates of 14 percent in nursing homes and 7 percent in home care agencies in Florida appeared in all categories of personnel: registered nurses, licensed practical nurses, nursing aides, social workers, physical therapists and others. To maintain adequate staffing, Florida nursing homes spent over 3.5 million dollars on short term temporary staff from personnel placement agencies in 1987.[15]

Implications and Trends

Because of the low status of long term care workers and chronic shortages of personnel, a number of trends are occurring to assure our elderly receive care. These include some of the following points. First, there is widespread use of temporary personnel which is more costly and provides less continuity of care for long term care clients. Second, there is insidious substitution of technology for personnel. For example, in Florida, computerized client assessment managed by entry-level low wage workers serves as a substitute for assessment decision-making by higher paid, better prepared professional personnel. Third, policy incentives are in place to replace paid personnel with more care by family and friends, even though some 80 percent of care of the elderly is by informal unpaid caregivers. This is evidenced in more out-patient medical procedures and surgery with before and after care on an out-patient basis as well. And fourth, policies like certificate of need for new nursing homes and/or reimbursement levels restrict labor intensive institutional care, substituting care provided by family members and intermittent home-based services requiring less resources. Another trend which is becoming widespread, either by policy incentives or because of shortages of services personnel, is the training of young-old to care for old-old -- and to provide these caregiving services as volunteers. Many proprietary providers are supplementing staff by importing personnel, resulting in a brain drain of health providers from donor countries, such as the Philippines and Ireland.

Nelson Chow (1986), from the Chinese University of Hong Kong, identifies four stages in the development of long term care systems for the elderly:

Stage 1. All care is from family members.
Stage 2. Charitable institutions substitute for some family care.
Stage 3. Public services supplement family care.
Stage 4. Integrated family, public, and proprietary (paid) service.

In the U.S. we have moved from not-for-profit voluntary and public services (Stages II and III), to largely for-profit, proprietary corporations providing care for the elderly for payment -- supplementing family care (Stage IV). However, full integration of family, public and proprietary services has not occurred.

As one can see from salaries, job benefits and working conditions in these proprietary facilities in the U.S. we have given low employment status to those who care for our frail elderly. Compounding the problem is the issue of the overall cost of long term care -- which results in the spend-down of income resources of frail elderly and their families. Thus, there is the unsolved dilemma of how to make care of the elderly an attractive career and one which will support the worker adequately and yet at the same time provide nursing home care at a cost the average citizen can afford.

Until dignity reigns for the care providers of the elderly, we will reflect the real social value of the elderly in our society. Low status long term care workers translate into low social esteem for our elderly population. Those countries that are moving into the 4th stage of health and long term care systems will need to assure that policy planning will make provisions for the care of an increasing older population, avoiding some of the dilemmas faced in the United States.

References

1. *Communications, 3* (5) September/October, 1987, 1.

2. Alleway, L. (1986) . Staff shortage: Planning for a crisis. *Nursing Times* , *82* (14), 18-19.

3. Florida Hospital Cost Containment Board (1988), Personal communication.

4. Carlson, S.M. & Cowart, M.E. (1988). *Shifts in the supply and demand for nursing and other health care personnel in the 1980's.* Tallahassee, Florida, Institute on Aging, Florida State University, 102 pp .

5. Flanagan, L. (1976) . *One strong voice.* Kansas City, Mo.: American Nurses Association.

6. Florida Hospital Association (1986), Personal communication.

7. Florida Department of Health and Rehabilitative Services (1987). *Florida health manpower reports: Registered nurse survey.* Tallahassee, Florida: Florida Department of Health and Rehabilitative Services.

8. Florida State Board of Nursing (1987). *Annual report.* Jacksonville, Florida: Florida State Board of Nursing.

9. "National Study shows sharp drop in number of college freshmen planning nursing careers," *American Journal of Nursing, 88,* 371- 378.

10. Florida Hospital Cost Containment Board (1988). Personal communication.

11. Curran, C. R., Minnick, A., & Moss, J. (1982). Who needs nurses? *American Journal of Nursing, 87*, 444-447.

12. Florida Department of Health and Rehabilitative Services (1987). *Florida health manpower reports: Registered nurse survey*. Tallahassee, Florida: Florida Department of Health and Rehabilitative Services.

13. Alleway, L. (1988) . Staff shortage: Planning for a crisis. *Nursing Times,* 82, 18-19.

14. Bureau of Labor Statistics.

15. Florida Health Care Association and Florida Association of Homes for the Aged. (1987). *Nursing personnel shortage: A Florida nursing home problem of crisis proportions.* Tallahassee, pp. 19.

CHAPTER 24

QUALITY OF CARE IN SHELTERED HOUSING: REGULATION OR EDUCATION?

Gordon F. Streib

The major purpose of the Pensacola conference was to bring together persons from different countries who share the goal of serving older persons in their homelands. We are keenly aware that we come from vastly different cultural backgrounds, and that our countries have different levels of resources to provide services for both old and young. As my theme, I have chosen quality of care in sheltered housing. I propose to view this complicated field in terms of how we might ensure quality of care through the regulatory approach or the educational.

As a sociologist, I view my subject as intersecting with the interests of people from many professional disciplines: social worker, public administrator, planner, architect, teacher, researcher, etc.

All of the words in the title require some preliminary definition, because we tend to use the words in slightly different ways. Quality of care has the meaning of excellence or superior grade in some particular field, such as housing. We speak of excellence or quality in regard to many things: foods, education, automobiles, workmanship in building, etc. Most people think of quality in terms of a rank system and usually imply that the word quality has the adjective "high" associated with it.

Sheltered housing is a British term, and is a special kind of supportive housing for older persons. British organizations have been pioneers in this field, but the idea behind sheltered housing is wide ranging and a variety of housing types can be considered as adaptations of sheltered housing. Such housing has different labels in different places: supportive housing, congregate housing, enriched housing, assisted living, leisure living, etc. The various kinds of housing are linked together by the kinds of people who live in them: persons who are functionally disabled, and who tend to be socially dependent. The term, "the frail elderly", has been used in the United States, but some professionals do not like the connotations of frailty even though it depicts reality.

Sheltered housing is more than a housing unit -- a place to live -- for it involves the dwelling unit, plus management resources, and the provision of some kinds of health and social services. However, it should be emphasized that whatever the various labels attached to sheltered housing, it is a kind of environment in which persons can maintain some independence consistent with their abilities to function. Sheltered housing is not an institution, a nursing home, or a geriatric residence. It is a point on the continuum between living completely independently in a separate house or apartment, and living in a nursing facility. This alternative kind of environment reduces some of the drift toward dependence that is part of the aging process for many persons.

Why is the State Involved?

One might ask, why must the state become involved in quality of care in sheltered housing environments, which are often pseudo-family types of housing? If an older person is not satisfied, why couldn't he or she simply leave? The issue of quality of care and the elderly is important because many older persons are in a dependent situation. Their physical and mental frailties make it difficult for them to present their complaints and problems to their caregivers. Some elderly may not recognize that their nutritional needs are not being met. They might not understand the need for some supervision of medication. They may not be aware of the need for smoke alarms and fire safety. Poor eyesight and loss of sensitivity to smell may make some of them unaware of poor standards of housekeeping and hygiene.

Other elderly might recognize the inadequacies in their living arrangements but may be reluctant to complain about them because of the fear that the alternatives might be worse. The elderly generally like stability -- thus the fear of having to move may be a frightening situation to contemplate. Furthermore, there may not be any other facilities in the area in which they wish to live, or the costs of other housing may be too high.

Thus the elderly -- like other dependent persons -- must have protection in order to guard their health and welfare, and hopefully maintain some tranquility and dignity in their lives. This is obviously difficult to carry out -- for it means that a government agency is taking over an activity that was formerly considered a function of the family. In Florida, for example, we have many persons who have moved here to enjoy their retirement years and then find themselves in late life far away from relatives and friends who might intervene in their behalf or act as advocates. Experts in the caregiving field agree that public scrutiny, public awareness and the presence of concerned outsiders -- whether relatives, friends or official inspectors -- are important components that ensure quality of care.

Regulation or Education?

The various types of housing which we observe in different countries providing shelter for the dependent elderly point to the need to consider the kinds of social control mechanisms utilized to ensure that some degree of quality is maintained. Quality of care can be a meaningless phrase unless there are some kinds of social controls that ensure that residents are taken care of adequately and safely. Beyond the establishment of basic standards of health, safety, comfort and nutrition, there is the important requirement that compliance with legal rules be achieved. Two basic approaches can be used: *regulation* -- the establishment of laws and regulations and some kind of enforcement system with penalties for violation; and the *educational* approach in which rules are established and non-compliance is handled by training, by conferences, and by demonstrations. The regulatory process stresses rules and their enforcement through inspection, fines and penalties. The second approach to monitoring quality of care is accomplished through instruction and training. The educational approach emphasizes the roles of teacher.

The Regulatory Structure. The State of Florida over a period of years has enacted into law a detailed statute that has been amended a number of times. The law specifies the process of licensure, the sale and ownership of a facility, examination of the residents, the resident bill of rights, closing of a facility, the right to entry and inspection, maintenance of records, and reports, etc. The law has been further specified by rules set forth in the Administrative Code and they provide additional specifications which affect quality of care in an ACLF (Adult Congregate Living Facility). The law and the rules for the ACLF are related in certain formalities to those governing nursing homes, but the nursing home laws and regulations are more detailed and more stringent because nursing care and the use of medication are involved.

To give an idea of the detail in the legal structure, even such matters as emotional security and emotional support are mandated. The regulations state that an ACLF should assist "the resident and the family or the family support network to cope with personal problems during periods of stress." Here we note that there is concern for the needs of the residents and also for their significant others.

The Office of Licensure and Certification is designated as the official agency to survey the facilities in order to ensure compliance with the law and the administrative code. An annual site inspection is mandated in which a detailed form comprising over 118 items is checked to determine whether the ACLF should be certified for continued operation.

Education and Training. The State of Florida has an excellent normative framework with laws and regulations relating to the major elements of quality of care. However, the education and training aspects are only in their formative state. It has been only in recent years that the manager of an ACLF must enroll in a training course provided by the Office of Aging and Adult Services. A detailed curriculum and a casebook have been provided that cover the major aspects related to the operation of an ACLF. However, there is no test of knowledge or competency involved. Education is a weak link in the system.

The educational and training aspects need further development because many of the employees -- cooks, maintenance workers, personal helpers -- are unskilled persons paid a minimum wage. In some facilities, there is a high turnover of these lower paid persons. There are complicated reasons for this situation: market demands, labor costs, profit margins, etc. The administrator of an ACLF must compete in the labor market for some of the same unskilled persons who work in fast food franchise businesses (McDonald's, Wendy's, etc.) However, working in an ACLF demands extra skills and understanding that go well beyond those required to prepare and serve fast foods. Currently, much more time and care is devoted to training persons to bag a hamburger correctly than to taking care of frail persons in an ACLF or nursing home. We must find means -- not only in Florida but throughout the U.S. -- to raise the quality of the staff in ACLFs and other facilities that take care of older persons. This is a complicated topic, and I mention it because many of us in all aspects related to aging are aware of it. Solutions will not come easily nor will they come soon, nor will they be cheap. It will take time and money, in my opinion, to develop an effective program of education and training.

Florida: A Case Study

In order to illustrate how quality of care is involved in the regulatory and educational processes, I would like to use the example of the Adult Congregate Living Facilities found in Florida. These are licensed environments which provide room and board and one or more personal services for adults. They differ from the British type of sheltered housing which generally does not provide meals in a congregate setting. At the present time, there are almost 1,600 Adult Congregate Living Facilities (ACLFs) in which almost 60,000 persons live. The ACLF facilities vary greatly in terms of size, furnishings, and setting. Most facilities are former single family homes with two residents to a room and are operated as a "for-profit" business.

Almost two-thirds of the ACLFs in Florida are licensed for 16 beds or less. Over forty percent are licensed for under nine beds. This means that there are 600 licensed small homes in the state with nine beds or less.

They are family-type arrangements and what some persons call "Mom and Pop" facilities. Some ACLFs are part of life care or continuing care facilities. About ten percent of the residents are supported by a state-subsidized payment; the majority of the residents are private payers. The cost ranges widely, from around $500 per month up to $1,500 per month. However, the average cost, which ranges between $700 to $900 per month, is less than one-half the cost of a nursing home.

The majority of the residents (about 70%) are older, white, widowed females who do not need legal guardians. The average age at entrance is in the late seventies. Although ACLFs are not nursing facilities, it is estimated that from one-quarter to one-third of the residents could meet the criteria for admission to a nursing home. The majority of the ACLFs provide adequate care.

In a survey conducted by the Department of Health and Rehabilitative Services, 84% of the facilities were rated "good". Employing a five-point scale, teams of site visitors rated about two-thirds of the facilities in the top half of the scale. The only item of the seven criteria which was rated low was the level of activity of the residents.

The Care Triangle

ACLFs in Florida are part of a complex triangular relationship involving the people and organizations involved in quality care. At the top of the triangle are the older persons who live in the facilities. Their health and welfare and the quality of their lives are the central concern of the two other sets of actors in the triangle of care. The other two are the regulative structure of the state, and the ACLFs as business organizations. Thus we find that all three sets of actors (persons and organizations) are involved in the process of ensuring quality of care in the facility. At the top of the triangle of care, in addition to the residents themselves, are family, friends, and some voluntary organizations (such as churches and religious organizations). The regulative structure involves the various offices of the government of Florida: the Office of Aging and Adult Services, Office of Licensure and Certification, and other government agencies concerned with fire, health, etc. The actual delivery of services is carried out by the many business organizations operating in a capitalist, free enterprise system. The owner, administrators, and staff must operate in a complicated market system providing shelter, food, care, concern, and a kind of family-like atmosphere to the residents who are their "customers."

Because ACLFs are business organizations, they operate in the same general business context as do other enterprises in their areas. In some parts of the state there is a competitive business climate in which ACLFs must be assertive in seeking residents in order to cover basic operating costs. If an ACLF does not achieve a break-even occupancy rate for a given period of time, it will, in time, be forced out of business. There is a small percentage of failures and some turnover of facilities. Administrator burn-out is sometimes a cause for selling out or closing down the facility.

In addition to maintaining an acceptable occupancy rate, an ACLF must have employees who can deliver the services and personalized care to the residents. As is true of other kinds of sheltered housing, an ACLF operates 24 hours of the day, 365 days in the year. It does not close down for the weekend or for holidays. Further, it is much more than a restaurant or hotel, for it must often provide personal services such as assistance with eating, bathing, grooming, dressing, and ambulating, plus for some residents, the supervision of self-administered medication.

With this complicated set of tasks and activities to carry out, an ACLF requires sound management, and the management must recruit and maintain employees who are able to provide quality of care to a specialized, often dependent resident population. It also places considerable responsibility upon the state agencies that are involved in the regulatory and educational processes to maintain and enhance the quality of care.

Learning From Others

In relation to my subject: quality of care -- education or regulation? -- I would like to use an example of how we Americans have borrowed an idea from another country and adapted it to our needs in the field of aging. The concept we Americans have borrowed is that of *ombudsman*, a position originally created in Sweden, then transferred to other Scandinavian countries, and now widely used in the aging field in the United States.

The idea of the ombudsman as originally used in Sweden in the early part of the nineteenth century was that he was a person to whom a citizen could go if the citizen thought he/she had been mistreated by a public official. Behind the ombudsman concept was the realistic possibility that public officials and civil servants may be arbitrary, unfair or indifferent in how they handle public business. Citizens should be able to go to someone to register a complaint if they have a grievance about how they had been treated. A governmental system enjoys greater public confidence and support if the average citizen thinks that all persons -- regardless of rank, income or educational level -- can complain to a person who has the authority to determine if there has been unfairness in the way the laws are carried out or if benefits that are derived from public resources have been distributed in an equitable manner.

The Swedes created the ombudsman as the most prestigious person in the government structure. The ombudsman stands outside the traditional government structure and can determine if a complaint from a citizen has merit. The ombudsman has the power to rectify the situation so that the laws are fair and truly universal -- in that they apply to all citizens in the same manner.

In the United States, the ombudsman position has been considerably modified, and we in Florida are particularly proud of how we have adapted an idea from another culture to our needs in the care of the elderly. The background for the ombudsman adaptation in the United States arose out of scandals in a few of our nursing homes. Older persons were being mistreated and exploited in some of our nursing homes, and many changes were instituted to deal with these problems. In 1975 the people of Florida and their representatives in the Florida Legislature realized there was a need to provide an alternative to then existing methods of correcting deficiencies in our nursing homes. It was determined that the conditions in nursing homes were such that health and personal care of the residents were not guaranteed through the regulatory efforts of the Department of Health and Rehabilitative Services, or through the good faith and behavior of the persons who own and operate nursing homes.

The Florida Legislature recognized that concerned citizens are effective advocates, and sometimes they are more effective than government agencies. Thus they created an independent system of state and district Long-Term Care Ombudsman Councils in the Office of the Governor. This means that there is a council for the entire state, and there are eleven district councils coinciding with the HRS districts in the state.

From 1975 through 1987, Florida ombudsmen have investigated 10,243 cases on behalf of the elderly residents of our long-term care facilities -- both nursing homes and ACLFs. Furthermore, during the fiscal year 1986-1987, the ombudsman coordinators processed almost thirteen thousand (12,897) information and referral contacts concerning facilities for our older citizens.

One of the important modifications that Florida has made in the ombudsman system is that most of the basic work of the councils -- state-wide and in the eleven districts -- is carried out by volunteers. Each district has a paid coordinator, and the state office has only a four person staff, including the state executive director. The use of volunteers is not permitted in Sweden in any aspect of the health and welfare system. For a number of complex reasons, Swedes do not think it is advisable to use unpaid persons -- volunteers -- in such work. In the United States we rely on volunteers for many aspects of our health and welfare system, not only as it pertains to the elderly but also in regard to children, the disabled, the operation of hospitals, and clinics, etc. As I stated at the beginning of this section, the United States has adapted a Swedish concept consistent with our cultural values and administrative procedures. I would emphasize that many of us here in the West realize that each nation will have to develop its own health and welfare system consistent with its own values and traditions.

The process of the transfer of cultural practices can be many-faceted. Ideas and practices may be transferred from one society to another. Some are more easily accepted than others. When I and a fellow gerontologist, Marie Cowart of Florida State University, were in Taiwan in 1986 at the Asia/US Conference on Social Service and Aging Policies, we were impressed with the taxi nurse system which works very well in providing home care for the elderly. We think it has possibilities for other places and we wrote a short article about our observations. There are several definite advantages to nurses going to the homes of older patients in taxi cabs: fares are low, no capital outlay or high monthly subsidy to the staff is required, the taxi system promotes physician-nurse communication, and there is planning for care of specific patients.

Conclusion

In this brief chapter I have tried to specify some of the aspects involved in quality of care in sheltered housing. My title asks a question -- regulation or education? The answer is that both regulation and education are required to ensure quality of care. In Florida we have answered the quality of care question by emphasizing the regulatory approach. But we are cognizant of the need for more education and training. Regulation tends to be adversarial and may result in non-compliance. It tends to have a short-term effect while education and training may have longer-term and more permanent consequences. Education may discover the underlying reasons for non-compliance and the changes may be sustained. The effects of the regulatory approach may result in short-term conformity -- grudgingly and with limited realization of why the standards are important.

Providing quality living arrangements is a complicated enterprise, and we in Florida and in many other states have endorsed the private business approach with a regulatory system. Other societies have used other methods. The Florida method is perhaps not the answer for other places. I have also shown how the importation of the ombudsman system has been adapted to the values and practices of this state in order to enhance quality of care. It is an ingenious combination involving both regulation and education. My major purpose has been to show that quality of care is complex and has many facets.

CHAPTER 25

FINANCIAL MODELS FOR LONG-TERM CARE: USA

Nancy Sutton-Bell

Developing and expanding private programs for funding long-term care represents one of the major challenges and opportunities facing financial planners and the insurance industry today. Of all demographic groups, the middle-class elderly are the most vulnerable to having their savings and assets depleted by high health care expenses. The current lack of viable private options is highlighted by the fact that the elderly represent one of our nation's most affluent age groups,[1] yet many exhaust personal resources and are unable to remain financially independent if a lengthy nursing home stay becomes medically necessary.[2] As the elderly group is expected to grow both in terms of numbers and affluence,[3] developing private programs for financing the health care needs of the elderly will be necessary to assure the financial security and dignity of Americans during their golden years.

The graying of the population will increase the numbers in need of long-term care. Long-term care refers to the financing, organization, and delivery of a wide range of medical and social services needed by individuals who are severely disabled or limited in their functional capacity for a relatively long period of time. While modern medicine has made significant breakthroughs which have increased life expectancy, there has also been a corresponding increase in the prevalence of chronic diseases that cause functional impairment. Approximately 20 percent of the nation's elderly have chronic illnesses, and 40 percent will enter a nursing home sometime during their life.[4] The numbers of elderly needing long-term care is certain to increase as demographic projections indicate that 13 percent of the population will be over age 65 in the year 2000 and, by the year 2020, the baby boomers will expand the number of elderly to 20 percent of the population.[5]

Long-term care represents one of the most potentially financially catastrophic risks faced by the elderly. Medicare, the major health insurance program for those 65 and over, was designed to pay for medical expenses during acute illnesses, and provides relatively little long-term care coverage for expenses such as a nursing home stay. While most nursing home residents enter the facility as a private paying patient, because nursing home care costs an average of between $25,000 and $30,000 a year,[6] their personal savings and assets may be quickly depleted in paying for this care. When these assets are depleted to below the poverty level, patients become eligible for Medicaid welfare funds. As a result, about two-thirds of the nursing home patients are Medicaid recipients.[7] Medicaid was not designed to fund or service a largely middle-class group of clients. Developing and expanding private options may more appropriately channel the resources they are already using. The challenge to financial planners and the insurance industry is to improve society's ability to finance and deliver long-term care services in a more efficient, effective, and equitable manner. Because many of the elderly have sizable personal assets and there has been growing dissatisfaction with public programs, it is likely that the private sector will play important roles in developing methods for reshaping the financing and delivery of long-term care services for the elderly.

It is the purpose of this paper to survey some of the private funding options which may be expanded or developed to finance or deliver long-term care services in a more efficient and effective manner. Three categories of private funding options will be discussed: 1) insurance plans, 2) cash accumulation plans, and 3) service plans. The advantages and disadvantages of various plans under each of these categories will be discussed, and the potential each of these options offers in expanding the role of the private sector in funding long-term care will be considered.

Insurance Plans

The insurance mechanism offers considerable promise in filling some important gaps in our nation's health care financing system and preserving the financial security of many of our nation's elderly. One study estimated that Medicaid expenditure would be reduced by 23 percent if only half of the persons between ages 67 and 69 were to purchase long-term care insurance.[8] Furthermore, this alternative is affordable to the large middle class of elderly Americans who could be financially devastated by a long-term care need. It has been estimated that 80% of the elderly in the age group between 65 and 69 could afford to buy long-term care insurance for less than ten percent of their income, and 50 percent could afford this protection spending less than five percent of their income.[9]

The challenge to the insurance industry is to provide actuarially sound products at affordable prices covering a risk that has both a high probability of occurring and a high potential severity in terms of cost. Because the prevalence of functional impairments among the growing elderly population is a relatively new phenomenon, many insurers lack actuarially sound data for evaluating the long-term care risk. Insurers have expressed concern over potential adverse selection, insurance-induced demand for services, administrative economies, pricing difficulties and the dilemma of adequately funding a benefit that may not be paid until far out into the future.[10] However, the market potential for long-term care insurance is large, and the number of insurers entering this market has grown dramatically in just the past couple of years, despite problems with pricing and underwriting this risk.[11]

Long-term care policies offer consumers a wide range of coverages and premiums. Policies will vary on the services covered, daily limits on covered facilities, renewability provisions, prior in-patient hospitalization requirements, exclusions, and maximum benefits payable. A recent survey of 33 insurance policies found that daily limits on covered facilities ranged from less than $10 to $120 per day, and the premiums charged ranged from $20 to over $7,000 per year.[12] In an effort to establish a uniform definition of long-term care insurance which would assure consumers a reasonable standard of protection from any product marketed as long-term care insurance, the National Association of Insurance Commissioners has proposed a model regulation for adoption by the states. While states are considering adoption of this model definition, the burden of evaluating whether or not a long-term care product is adequate is left to the consumer.

Individual Indemnity Products

Individual indemnity products are generally available as a separate personal insurance policy, and most companies will individually select applicants according to medical information provided on an application. The premiums will vary according to the coverage provided by the policy, as well as the age, sex, and health of the individual.

Individual indemnity products present some disadvantages in insuring long-term care. The policies may be expensive as the cost of marketing and underwriting the policy is passed on to the individual. The cost will frequently increase with age as health deteriorates with age; the policy may become unaffordable. Because most individual plans utilize individual underwriting, elderly persons who are not in good health may be unable to qualify for individual insurance protection.

However, individual plans offer some distinct advantages. Because individuals shop for their plan, they can select plan features such as high daily maximums or coverage for home health services that may be particularly appropriate for their personal financial and social situation. Healthy applicants may be expected to be able to get broad coverage with favorable renewal provisions and few exclusions at a reasonable price. Additionally, a particular consumer may not be the member of a group which offers long-term coverage, and individual protection may be his/her only insurance option.

Group Indemnity Products

Group products are generally offered to a group of individuals such as current and retired employees of an employer or members of an association such as the American Association of Retired Persons. The policy is issued as a master contract for the group, and insureds receive a certificate which summarizes their coverage. A recent survey indicates that 38 percent of companies with 500 or more employees provide health care coverage for their retirees after age 65.[13] Major insurance companies appear to be recognizing this need and aggressively pursuing this market.[14]

The main disadvantage presented by group coverage is that individual policyholders are not able to select plan features such as covered services and coverage amounts. However, a recent study which compared 48 group products with 56 individual products concluded that group products generally offer more adequate long-term care protection.[15]

There are a number of reasons to think that the group insurance mechanism may offer more potential than individual coverage in financing the long-term care risk. Group insurance may be based on a broader classification of policyholders. This broad-based group precludes individual selection, thereby providing protection to unhealthy elderly who would not otherwise qualify for insurance and may include healthy younger individuals in spreading the risk. Group strategies also reduce the portion of the premium which is associated with the expense of individual marketing and underwriting. One study, which estimated that nearly half of the recent retirees could afford long-term care insurance, estimated that nearly 70 percent could afford coverage if premiums could be reduced by 20 percent.[16] The administrative economies of the group mechanism offer this potential.

Insurance offers some unique advantages in financing the long-term care risk. The insurance mechanism spreads the financial impact of the large losses of the unfortunate few among the many exposed to the loss. In exchange for a small certain cost, the premium, individuals are assured that a potential medical expense which may be devastating to them personally is the event which will activate the insurance mechanism providing the funds to remain financially independent. Expansion of, and development of, long-term care insurance products may play an important role in increasing the role of private plans in funding the long-term care risk.

Cash Accumulation Plans

Cash accumulation plans can help people save money in order to have the personal resources to finance long-term care. Developing or encouraging private savings plans such as Individual Retirement Accounts or Individual Medical Accounts, home equity conversions, and life insurance or annuity products may provide extra funds for financing the long-term care needs of the elderly.

Individual Retirement and Individual Medical Accounts

Individual Retirement Accounts (IRAs) allow individuals to accumulate funds during their working years in a tax-favored manner. Under current tax laws, IRA contributions up to $2,000 annually may be deducted from the taxable income of workers who are not covered by a pension plan, individuals who earn $25,000 or less, or married couples filing a joint return earning $40,000 or less a year. The tax deduction is reduced for individuals earning between $25,000 and $35,000, and no deduction is available for those earning $35,000 or more annually. Regardless of the tax deductibility of contributions, tax on the interest earned on IRAs is deferred until the money is withdrawn. Since funds may only be withdrawn without tax penalty at age 59 and one-half, disability, or death, the IRA may be used to accumulate funds to finance the future needs of workers.

A tax-favored savings device similar to the IRA, called an Individual Medical Account (IMA) has been recommended by the Department of Health and Human Services to encourage private savings for long-term care needs.[17] The IMA account would allow workers to make tax-deductible contributions to an account that would accumulate tax-free to finance future health care services or premiums to pay for long-term care insurance.

It is questionable whether or not IRAs or the proposed IMAs would provide substantial private savings for long-term care. Most workers are not currently participating in IRAs. In 1985, only 16 percent of the taxpayers claimed IRA deductions, and this percentage can be expected to decrease, as the Tax Reform Act of 1986 removed the deduction for higher income workers. The IMA would probably be less attractive to workers than the existing IRA because the IMA would further limit how savings could be spent. Even for workers who may save in such accounts, the cost of a long-term stay in a nursing home could quickly deplete these savings.

Still, to the extent that workers save in IRAs or the proposed IMAs, the role of private savings in financing the cost of long-term care may expand. Current tax law, which provides greater incentives for lower income workers to save in IRAs, may encourage the income classes who are least likely to have private funds for long-term care to save for these needs. Restrictions on withdrawals help assure that funds will be used for retirement and medical needs rather than current consumption. As IRAs and the proposed IMA may give individuals incentives to begin accumulating funds at an early age, greater private savings may be available to help fund long-term care service.

Regulations which would increase individual tax incentives to accumulate funds in IRAs or IMAs would increase the role private funds may play in financing long-term care. Prior to the Tax Reform Act of 1986, workers could deduct contributions to IRAs regardless of income, and most IRA plans were established by taxpayers in the upper half of the income distribution. According to one study in 1983, 58 percent of taxpayers earning over $50,000 established an IRA compared to only 11 percent of those earning less than $20,000.[18] In order to increase the incentive to save in such plans, Congress would need to give tax deductions to workers paying tax at marginal rates sufficient to make the IRA or IMA attractive. Without such incentives the percentage of individuals and the amount of savings accumulated for long-term care may be expected to be relatively small.

Home Equity Conversion

Home equity conversions are financing plans that enable homeowners to draw upon the equity they have accumulated in their home while continuing to live in the home. Reverse annuity mortgages and sale-leaseback arrangements are the main types of home equity conversions which may provide elderly homeowners with funds needed for long-term care. The reverse annuity mortgage provides a monthly payment that represents a loan against the equity in the home. The mortgage grows as the monthly payments and interest increase. The loan must be repaid or renegotiated upon maturity which occurs after a fixed period of time or when the homeowner dies and the house is sold by the estate. Under a sale-leaseback arrangement, a homeowner sells the home to an investor at a discounted price. The investor takes full responsibility for taxes and maintenance of the home and guarantees the sellers the use of that home for the rest of their lives.

Due to the limited number of home equity conversions that have taken place, there is not enough information to determine their potential in financing the long-term care risk. According to one study, 25 percent of all low-income elderly could raise their incomes above the poverty level by drawing upon the equity in their homes and 40 percent of those over age 75 could use home equity to raise their incomes above the poverty line. While this would reduce the number of elderly eligible for welfare benefits, the elderly may be hesitant to give up this asset. The study also found that many homeowners could purchase home health services and long-term care insurance through a currently available long-term home equity conversion instrument.[19]

For the majority of elderly homeowners, their largest single asset is the equity they have accumulated in their homes.[20] Regulations which would further consumer protection could increase the attractiveness of reverse annuity mortgages. Because home equity conversion plans are legally complicated, a potential for market abuse may exist. Developing and expanding home equity conversion plans could provide substantial numbers of elderly homeowners with an alternative method of financing their long-term care needs.

Life Insurance and Annuity Products

Whole life insurance, universal life insurance, and annuity products are asset accumulation vehicles capable of helping to finance long-term care. These plans provide for tax-free accumulation of funds until payments are made under the contract. Cash or loan values are available to the policyholder which could provide cash needed for a medical emergency. Annuity options, available in many life, as well as annuity products, guarantee the policyholder a specified income from the accumulated cash values which will continue as long as the annuitant lives.

The main disadvantage of life insurance and annuity plans is that the savings accumulated are generally quite small. Based on a national consumer survey conducted in 1984 for the American Council of Life Insurance and the Life Insurance Marketing Research Association, the median amount of life insurance was only $13,000 for men and $5,000 for women. Cash accumulated by life and annuity plans would generally only cover a tiny portion of long-term care expenses. Still, such plans may be used to supplement other private funds during a long-term illness or used to pay the premium for long-term care insurance.

An inherent disadvantage of cash accumulation plans is that the amount of money saved is relatively fixed at the time of retirement. While savings may be adequate for planned personal expenditures, savings accumulated may prove to be inadequate if the individual incurs substantial long-term care expenses.

It is conceivable that the insurance industry could develop a product which would combine long-term care insurance with an annuity. Two professors developed a prototype plan which would provide $1,500 per month for long-term care or income after age 75 of $750 per month from an annuity. The cost for a couple at age 60 would be an initial payment of $9,700 and $125 per month. A balancing of risks would be achieved by those using the long-term care benefit being most likely to suffer early mortality, thus reducing the annuity benefits. The deferral of annuity benefits to age 75 allows accrual of interest as well as reduction in the numbers of beneficiaries.[21] This plan offers an example of how cash accumulation may be combined in an innovative manner with insurance guarantees for the long-term care risk.

Cash accumulation plans, without insurance, are inadequate for managing the long-term care risk. In the case of insurance indemnity plans the amount of money available automatically varies with the need for long-term care. Insurance instruments that involve risk pooling offer the elderly better financial protection, especially for the relatively infrequent case of having a long stay in a nursing home. Still, regulations that would encourage private cash accumulation through Individual Retirement or Individual Medical Account, home equity conversions, and life or annuity products may provide extra funds for purchasing plans or services which insure the long-term care risk.

Service Plans

Service plans such as social/health maintenance organizations and life care communities integrate insurance-type promises with the delivery of health care services. Because services are what the member receives from the plans, rather than dollars reimbursing them for incurred expenses as with insurance indemnity arrangements, these private funding options are labeled service plans.

Because service plans are both the providers as well as the financers of long-term care, they have a direct incentive to operate in an economic and efficient manner. Such plans are likely to utilize preventive techniques and low cost alternatives in arranging for the most economical and appropriate care needed by the elderly.

Social Health Maintenance Organizations

The Social Health Maintenance Organization (S/HMO) provides an integrated package of medical and long-term care services in exchange for a monthly premium paid by the elderly member or reimbursement by Medicare. The S/HMO extends the concept of prepayment for integrated acute care services provided in Health Maintenance Organizations to chronic long-term care services. S/HMO members who reside in the service area are voluntarily enrolled through the marketing effort of the S/HMO provider and, once enrolled, they must receive all services through the S/HMO provider.

S/HMOs are currently quite new and limited. They have only been developed since 1980, and are not available in most geographical areas. S/HMOs are now being tested at four sites with approximately 4,000 enrollees per site as part of a national demonstration project funded by the Health Care Financing Administration. The four demonstration projects are in Long Beach, California; Portland, Oregon; Minneapolis, Minnesota; and Brooklyn, New York. Early reports on the plans claim they have been successful in lowering the number of hospital days for enrollees and all four sites have met their budgets for the costs of providing medical and long-term care.[22] Recently, a major insurance company also began the first commercial HMO-based long-term care plan.[23]

Proponents of S/HMOs argue that these programs may allocate needed health care services to the elderly in a humane and economically efficient manner. The S/HMO serves as both the care coordinator and gatekeeper to control unnecessary utilization. The case management approach offers the potential to coordinate and manage the utilization of acute and long-term care services. Necessary medical services may be delivered to the elderly without requiring relocation to a more expensive skilled nursing home or retirement home, sale of the family home, or other disruptions to the normal life style of the member.

Life Care Communities

Life care communities (LCCs), also known as continuing care retirement communities, are housing-based programs that provide residents with health and social services, along with other amenities, designed to meet the continuing care needs of elderly residents in exchange for an entrance payment and monthly service fees. There are over 600 LCCs in the United States with entrance fees ranging from

$50,000 to $100,000 plus monthly service fees from $400 to $1500.[24] Most LCCs are 200-250 unit housing complexes with a package of social and medical services including emergency medical care, long-term nursing care, meals, recreational programs, transportation, and other services. Typically, a new member resides in his or her own townhome or apartment within the community and, as health problems increase, the LCC provides increasing levels of assistance from home health aids and home delivered meals to nursing home care.

The main disadvantages of LCCs concern the price and the financial stability of the facilities. Since the mid-1970s, at least 40 LCCs have declared bankruptcy or have experienced serious financial problems, mostly because they underestimated the long-term care costs of their residents. Some LCCs charge extra for nursing home care or other special services, and these charges may increase at any time.[25] In some LCCs the entry fee is non-refundable; however, the trend has been toward guaranteeing a substantial refund upon death or departure. The elderly consumer who is interested in moving to a LCC would be well advised to investigate the long-term care guarantees offered by the facility or be prepared to incur possible rising expenses.

For those elderly who can afford LCCs, they may offer many advantages. They offer a positive social environment with many organized activities, health care, and insurance guaranteeing provided services for the lifetime of the resident. LCCs are able to provide a case management approach to deliver care to their residents in an efficient and cost effective manner. The communities are designed to provide for the special needs of the elderly residents, and research indicates that LCC residents live long and use fewer acute health care services than other elderly.

Regulators may increase the viability of LCC plans in privately funding long-term care by developing standards which protect consumers. Currently, 17 states have adopted statutory approaches to regulate LCCs. The American Association of Homes for the Aging is developing quality standards, guidelines for actuarial planning, and accreditation programs to safeguard the financial soundness of LCC plans.[26] Such regulations may encourage the development and expansion of well managed LCCs which may provide for efficient and effective private funding of the long-term care needs of their residents.

Service programs offer considerable potential for expanding the role of the private sector in financing and providing long-term care for the elderly. These programs utilize case management in providing extended long-term care services on a risk sharing, prepaid basis. Therefore, economic efficiencies may be realized both in the delivery and financing of long-term care services for the elderly.

Conclusion

Achieving significant increases in the role of the private sector in financing long-term care will require the expansion and development of insurance, cash accumulation, and service plans. A comprehensive approach combining various private plans in innovative ways while meeting the different needs of elderly consumers will be necessary to dramatically alter the financing of long-term care.

For most of the elderly to have protection against the catastrophic expenses which may result from a long-term need for medical services, it is necessary they be protected by plans that have risk pooling, sharing, and transfer features. Indemnity insurance plans and service plans, such as life care communities and social/health maintenance organizations, utilize risk pooling and sharing techniques in transferring catastrophic expenses to the protected group. Therefore, the unfortunate few who suffer a large loss are adequately and equitably financed by others exposed to the risk.

Cash accumulation plans may prove to be inadequate in financing long-term care directly. However, such plans should be encouraged to provide extra funds to purchase insurance or service plans. Insurance indemnity products purchased at advanced ages may be quite expensive, and cash accumulation plans may provide the premium for this protection. Similarly, cash accumulation plans may enable some elderly persons to save the sizable entrance fee charged by life care communities.

Different private plans for protecting the long-term care risk need to be made available to meet the different needs of elderly consumers. While some elderly consumers will be attracted by the positive social environment and comprehensive services offered by a life care community, others will find this option unaffordable or will not want to leave their home to live in the facility. Some elderly consumers will like insurance indemnity products because they retain the freedom to choose their doctor and hospital, whereas others will be attracted by the comprehensive health care services offered by social/health maintenance organizations. Only by encouraging the development of many plans will the different needs of elderly consumers be met.

The development and expansion of the private plans discussed in this paper may dramatically increase the role of the private sector in financing the long-term care risk. Yet, there will be low income elderly who will not be able to afford these plans. The private plans discussed in this chapter were designed to provide middle-class Americans, who have resources and options for preserving those resources, in financing the long-term care risk.

As the development of these plans is only in its infancy, most middle-class elderly Americans are not protected. Currently, the main economic burden for financing long-term care has fallen on the elderly themselves, and once their savings and assets are depleted, Medicaid welfare funds pay these costs. Public budgets have been strained by serving this largely middle-class group.

Financial planners and the insurance industry may lead the private sector in developing and expanding private plans which will more appropriately channel the resources they are already using. The crisis in long-term care financing will get worse until private programs protecting this risk replace self-pay and government financing. Encouraging the development and expansion of private options for protecting the long-term care risk will help return the role of Medicaid to that of a safety net for the very poor, and preserve the financial independence of middle-class Americans.

Endnotes

1. Gregg Easterbrook, "The Revolution in Medicine," *Newsweek*, January 26, 1987.

2. U.S. General Accounting Office, *Medicaid and Nursing Home Care: Cost Increases and the Need for Services are Creating Problems for the States and the Elderly*. GAI/IPE-84-1, October 21, 1983 (Washington, D.C.: Government Printing Office, 1984).

3. Lynn Etheredge, "An Aging Society and the Federal Deficit," *Milbank Memorial Fund Quarterly*, Volume 62, Number 4, Fall 1984.

4. Health Insurance Association of America, The State of Long-term Care Insurance: Results from a National Survey, Washington, D.C., No. 5-86, November 25, 1986.

5. American Council of Life Insurance and Health Insurance Association of America, Growing Older in America: How the Baby Boomers' Parents View Retirement, *Council Review*, September, 1985.

6. U.S. General Accounting Office, "Medicaid and Nursing Home Care," 1984.

7. Ibid.

8. ICF Incorporated, "Private Financing of Long-Term Care: Current Methods and Resources, "Phase I and II, unpublished report to the Office of the Assistant Secretary of Planning and Evaluation, Department of Health and Human Services, January, 1985.

9. Ibid.

10. Health Insurance Association of America, The State of Long Term Care Insurance, November 25, 1986.

11. National Association of Insurance Commissioners Industry Advisory Committee on Long-term Care, *Long-Term Care: An Industry Perspective on Market Development and Consumer Protection*, June 9, 1986, unpublished report.

12. U.S. General Accounting Office, "Long-Term Care Insurance: Coverage Varies Widely in a Developing Market," GAO/HRD-87-80, May, 1987 (Washington, D.C.: Government Printing Office, 1987).

13. Elizabeth McMartin (ed.), "Looking to the Future of Retiree Health Benefits: Equicor Health Care Survey VI," *Medical Benefits*, February 15, 1987, pp. 9-10.

14. For examples of activities in this market, see Spencer Vibbert (ed.), "Travelers Offers Long-term Care Plan," *Long-term Care Management*, Volume 16, Number 1, January 8, 1987, pp. 7-8, and "Aetna Initiates Group LTC Coverage," *Long-term Care Management*, Volume 16, Number 6, March 19, 1987, p.7.

15. Nancy A. Sutton, "Long-term Health Care: A Comparison of Group and Individual Products, " *Benefits Quarterly*, Volume III, Number 4, Fourth Quarter 1987, pp. 23-30.

16. ICF Incorporated, "Private Financing of Long-Term Care," January, 1985.

17. Spencer Vibbert (ed.), "Reagan Approves Catastrophic Plan, Little for LTC -- Critics Charge," *Long-term Care Management*, Volume 16, Number 4, February 19, 1987, p. 2. Association for Advanced Life Underwriting, Washington Report 85-43 (Washington, D.C.: Association for Advanced Life Underwriting, 1985.)

18. Association for advanced Life Underwriting, Washington Report 85-43 (Washington, D.C.: Association for Advanced Life Undrewriting, 1985.)

19. Bruce Jacobs and William Weissart, "Home Equity Financing of Long-Term Care for the Elderly, "Long-Term Care Financing and Delivery Systems: Exploring Some Alternatives, January 24, 1984, p. 86.

20. Bruce Jacobs, "Home Equity Conversion: Issues and Options for the Elderly Homeowner," A Joint Briefing by the Subcommittee on Housing and Consumer Interests of the Select Committee on Aging, House of Representatives and the Special Committee on Aging, United States Senate, January 28, 1985, p. 14.

21. Thomas E. Getzen and Charles P. Hall, "Achieving Financial Security Throughout Retirement: The Long Life Insurance Plan," *Benefits Quarterly*, Volume III, Number 4 (Fourth Quarter, 1987), pp. 10-22.

22. B. F. Goffney, "The Clock is Ticking for S/HMOs," *Long-term Care Management* , Volume 16, Number 9, April 30, 1987, p. 6.

23. Spencer Vibbert (ed.), "Met Life, HMO Joint to Offer LTC Coverage" *Long-term Care Management*, Volume 16, Number 6 March 19, 1987, p. 8.

24. Report of the Governor's Private Sector Task Force on Long Term Care (Arizona), 1986, p. 19.

25. Department of Health and Human Services, Technical Work Group on Private Financing of Long-Term Care for the Elderly, "Report to the Secretary on Private Financing of Long-Term Care for the Elderly," November, 1986, pp. 3.79-3.80.

26. American Association of Homes for the Aging, "Current Status of State Regulation of Continuing Care Retirement Communities," January, 1987, p. 2.

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